Supreme Court, U. S.
FILED
JUN 18 1976
MICHAEL RODAK, JR., CLERK

VOLUME II—Pages 435a-865a

APPENDIX

In the Supreme Court of the United States

October Term, 1975

No. 75-1064

JACK B. KREMENS, Individually and as Hospital Director of Haverford State Hospital; FRANK S. BEAL, Individually and as Secretary of Public Welfare of the Commonwealth of Pennsylvania; WILLIAM B. BEACH, JR., Individually and as Deputy Secretary for Mental Health and Mental Retardation of the Department of Public Welfare of the Commonwealth of Pennsylvania,

Appellants

v.

KEVIN BARTLEY; STEVE GENTILE; LESLIE LEVINE; VICKI MATHEWS; MARK WEAND; Minors, Through Their Next Friend, Individually and on Behalf of All Others Similarly Situated,

Appellees

APPEAL FROM THE JUDGMENT OF THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

APPEAL DOCKETED JANUARY 27, 1976
JURISDICTION NOTED MARCH 22, 1976

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MR. FERLEGER: There is no indication that the Director cannot then have the examination under 402 (b) or the examination done by the referring facility.

A. I would think that quite unlikely in view of the wording of this.

BY MR. ROTH:

Q. Doctor, Mr. Ferleger questioned you whether or not you have any objection to the Court working harmoniously with the psychiatrist, and then he sort of led you down the primrose path (86) of questioning whether or not facts should be presumed to the Court.

In essence, viewing the purpose of this lawsuit and knowing full well what is sought in the way of relief, I am questioning whether you feel that juveniles should be allowed to admit and release themselves at will as adults are?

A. No.

Q. And could you—I'm sorry if we have to be repetitive. We just have to clarify this.

Could you indicate why?

A. For the reasons of the incomplete emotional, intellectual, physical, hormonal things that the adolescent has not achieved yet and that he is under the care and responsibility of the parents, and the parents are the responsible parties. So, if a youngster feels so threatened, so disturbed that he feels he wants to be admitted and somehow he hasn't gotten the message across to his parents and he presents himself for admission at a psychiatric facility and the proper examination is done, and the diagnosis is made indicating he needs admission, then in that case the admission could be followed through with parental approval. If not, then approval of the law would be sought.

In other words, if a youngster needs to be admitted because he is a threat to himself and society and the parents say no, then the physician has a choice of contacting the law and saying make a judicial hearing to admit in spite of the (87) parents' objection.

Q. That goes along with the example before if a child wanted assistance and came to you, and even though the parents did not want to institutionalize the child, and even under our current safeguards, if you will, that would not likely happen in that there would be a referral to the institution, but nonetheless, assuming a child came to the institution and was begging for help and you, in your opinion, felt that the child needed help, although you may like to institutionalize a child at that point, you would be precluded from that, according to the law, correct?

A. Right.

Q. Now, however, that would not preclude you from seeking—from petitioning the Court?

A. Yes.

Q. In order to have the guardianship of the parents relieved?

A. Yes.

Q. With regard to the determination of adults and how they are admitted involuntarily into Pennsylvania and since we have not addressed ourselves to this section because, as you say, and we discussed, we were questioning your professional opinion in connection with juveniles and the treatment of juveniles and adults, Doctor, under Civil Court commitmments in Pennsylvania, and I state under Section 406 so you have a better understanding in terms of the questions that were asked of you before "Whenever a person is believed to be mentally disabled and in need of care (88) or treatment by reason of such mental

disability, an examination of such person has been made by a physician or physicians or for any reason the examination of such person shall not be made, a petition may be presented to the Court of Common Pleas of the county in which the person resides or is afforded a medical examination or commitment to an appropriate facility for examination, observation and diagnosis."

Then it goes on to say "By whom the petition can be made which may be a guardian, friend, individual standing in loco parentis or by an executive officer or authorized agent of a governmental or recognized non-profit health and welfare organization, or any responsible person."

Now, the petition sets forth the facts upon which the petitioner bases his belief of mental disability and the efforts made to secure an examination of the person by a physician. Then, the Court, upon consideration of the petition, issues a warrant requiring that the person be brought before the Court; fixes a date for the hearing and notifies the parties in interest.

After the hearing the Court can order an immediate examination by two physicians or order the commitment of the person believed to be mentally disabled. However, that commitment will not occur for longer than 10 days and there will be a report back to the Court and another hearing will be held.

Now, that is basically the way a Civil Court commitment occurs for an involuntary, committed adult in Pennsylvania.

(89) MR. FERLEGER: Is that a question?

BY MR. ROTH:

Q. And the question which I am leading up to is do you feel that juveniles who do not wish to be institutionalized ought to be afforded the same procedures as adults?

A. No.

You are viewing the issue that someone is taking the responsibility for him which is the parents, and you are abrogating their responsibility, and you are abrogating the considered opinion of psychiatrists who have made an assessment and a diagnosis and recommendation.

Q. Now, Doctor, in connection with a juvenile who does not want to be admitted to an institution and he is objecting, as the plaintiffs are saying, well, you may render an opinion saying that the child needed this institutionalization and some other doctor may say he does not, and there should be a finder of fact and that we should go to the Court then and have a judicial proceeding. How would you resolve that type of conflict?

A. I'm afraid I missed the first or the second part.

Q. If you feel that you have seen a child and the parents have explained the history, et cetera and you feel that the child warrants institutionalization—

A. Yes.

Q. —and the child is objecting and another psychiatrist evaluates the child, my question is whether or not the child (90) needs institutionalization at that point, what would you feel ought to be done at that point? Do you feel that it is necessary then to go before the Court as the plaintiffs would like to do, or do you feel that any other avenue could be resolved?

A. Well, there may be a different slant.

The second psychiatrist got from some bit of data that was admitted or that was not stressed or brought insignificantly in the first evaluation. So, if there is some kind of difference of opinion it might be useful for the two psychiatrists to come together to discuss what they feel and have a conference about it to see where they differ, or it

might be useful to have a third psychiatrist assess the two situations and evaluate the child and see what he thinks about it because there can be a difference of opinion. There are differences in theory and differences in approach in various situations.

So, if the parents are interested in handling the patient suitably they will have that further evaluation and check it out and have an opinion rendered that assesses all the possible facts.

Q. In other words, you feel that it can be handled by the psychiatrists?

A. Yes.

Psychiatrists can call for consultation or the parents can call for consultations of another person.

Q. Doctor, in connection with the harmonious working together (91) of the Court and psychiatrists, it is my understanding now that you feel the Court can come into play after the commitment. However, it is imperative that in order to preclude any delay of treatment of the juvenile, and it is based upon his chronological age which is imperative and indicative of his developmental state, et cetera, et cetera, that it is necessary to render treatment as quickly as possible; is that not correct?

A. Yes.

Q. And then if a judicial proceeding were to occur it would occur after admission; is that correct?

A. Yes.

Q. Assuming that children were allowed to admit and release themselves, would you find a lot of children who would engage in the use of drugs to be institutionalizing themselves on a Friday night late and then asking out early Saturday morning? Do you think that would occur?

A. Yes, unfortunately.

It might again be sort of a parody of utilizing the youngster to be his own physician instead of the physician making an assessment for which they are trained to do and do what is needed for the youngster because if he just admits himself and he says I want to go out tomorrow without an assessment, what has been accomplished?

Also where is the parents' responsibility? Are they being allowed responsibility for looking after the best interests (92) of their child since we assume in this society that the parents are interested in their children and look after their interests to the best of their ability?

If the youngster said "I want to go in the hospital tonight," it might be because he is afraid of coming home to see his parents which doesn't mean that he shouldn't be afraid. It means that the hospital may not be the place for him or the hospital might be the place for him. If it is, he should not be allowed to go out the next day and consider that what he went in there for 12 hours before is all suddenly vanished.

Q. Would you feel that juveniles whether admitted to State institutions or general hospitals, ought to be given hearings prior thereto if a child has, for example, an appendectomy to be performed and the parents want to place his child in a general hospital for the appendectomy, but the child refutes that? Do you think a hearing should be set up beforehand?

A. No.

Q. Why not?

A. Well, you might end up with a dead child or a child who has a ruptured gangrenous appendix or peritonitis instead of saving his life and avoiding the morbidity that peritonitis carries with it. You would have had the

whole thing dealt with properly in a couple of hours if the parent and the doctor were allowed to proceed, so that it would be to the child's interest and ultimate displeasure to have his wishes accepted since he (93) is not in a position to assess the fact that his pain in his abdomen is what it really is. He is not trained to assess it and he doesn't know the consequences, and the parents do have some idea about it, and the doctor makes a diagnosis saying surgery is indicated even though the youngster is frightened, which is the usual thing to be, and the usual thing is to object to it.

The needed course is what the recommendation should be in spite of the child's objection to it.

Q. Similarly then, juveniles would really be unaware of the degree of their emotional problem?

A. Just like adults, only more so.

Q. But there is enough of a distinction based on development and growth where an adult could make his own admission as is allowed by the law and released?

A. Yes, but it is still not on his own. It is still based on his feeling in his admission and psychiatrist's saying yes, you do have this condition. This diagnosis requires you to be in the hospital. This is still not the patient being his own doctor.

Q. Doctor, there has been some discussion about offspring of parents who suffer from severe emotional problems. Now, whether or not the parents have suffered or are suffering emotional problems, and based upon how a child becomes institutionalized in Pennsylvania, do you not feel that there is enough (94) of a review prior to the admission of any juvenile in order to determine whether the parent is using the child or whether or not the child actually needs institutionalization?

A. I think there is sufficient review and consideration of the total situation and proper safeguards by what the law currently has arranged.

MR. ROTH: I have no further questions.

BY MR. FERLEGER:

Q. Dr. Sugar, can you tell us what parts of the Pennsylvania Mental Health Law you became familiar with or read prior to this hearing?

A. These.

Q. All right.

Can you either indicate what they are or hand them to me, and I will indicate for the record. The papers you are holding—

MR. ROTH: Will you ask which portions of it you have?

BY MR. FERLEGER:

Q. I see you are holding the entire Mental Health Act.

Did you read the entire thing?

A. Yes, I looked through it.

Q. What other legal documents in preparation for this deposition did you read?

A. Exhibit A.

(95) Q. There are no such exhibits in the record.

A. Whatever these are.

Q. If you could either—

A. I don't know what you call these.

Q. Well, I can't see what you are talking about.

MR. ROTH: He read the results of the State Hospital Analysis.

MR. FERLEGER: I don't know what you are talking about.

MR. ROTH: The Summary Sheets.

MR. FERLEGER: The Summary Sheets to the interrogatories which were submitted to the Court in this case?

MR. ROTH: Right.

MR. FERLEGER: Okay.

MR. ROTH: This was about the new law lowering the age from 21 to 18.

MR. FERLEGER: Which was attached to an exhibit, I believe, Exhibit A.

MR. ROTH: To a Memorandum of Law which was also reviewed by him to your Complaint. This was to my answer to your Complaint, a Memorandum of Law of Sovereign immunity which was sent. This was in answer to interrogatories of the Court Order.

The additional regulations and our most recent Memorandum of Law—

(96) The last thing you referred to, the Memorandum of Law with regard—

MR. FERLEGER: That is—is it filed of record in this case?

MR. ROTH: Yes.

MR. FERLEGER: Well, the last memorandum you referred to, can you tell me what that is or let me see it instead of keeping it away from me?

MR. ROTH: Mr. Ferleger, I object to your obnoxious attitude, but I will be more than happy to give them to you.

MR. FERLEGER: May I see it?

MR. ROTH: It is a Memorandum of Law that was filed—we are trying to find a date on it. I think this may have been one of the first ones filed.

MR. FERLEGER: May I see it?

MR. ROTH: Yes.

BY MR. FERLEGER:

Q. So you have not seen any of the Memoranda of Law of the plaintiffs expressing their position; is that correct?

A. Just what I have seen.

Q. You have not seen anything with my signature at the end giving our opinion on the merits of the lawsuit, have you?

MR. ROTH: Just the Complaint.

THE WITNESS: This is what I have seen.

(97) BY MR. FERLEGER:

Q. Do you recall reading any memoranda or briefs with my signature at the end expressing our position of the plaintiffs on the merits?

A. I will look through it and see.

MR. ROTH: I object to this whole line of questioning in that it is irrelevant.

BY MR. FERLEGER:

Q. Is that also your answer, Dr. Sugar?

A. Yes.

Q. Dr. Sugar, you testified just now to Mr. Roth that juveniles shouldn't be allowed to admit and release themselves to institutions. What ages were you talking about when you used the word "juveniles" in that context?

A. The specification here being under 18.

Q. Do you believe that 19-year old adolescents ought to be allowed to admit and release themselves?

A. They are treated as adults. They have the majority. That is the law.

Q. I am not talking about the law. I am talking about their mental condition.

A. Yes. They are in a much more mature condition.

Q. Much more than the 18-year olds?

A. Yes.

Q. So, it is your psychiatric opinion that 19-year olds (98) ought to be allowed to admit and release themselves?

A. From a psychiatric evaluation.

Q. So your answer is yes?

A. It is not yes. It should be on the basis of a psychiatric evaluation.

Q. And it is your psychiatric opinion that with psychiatric evaluations 18-year olds should not be allowed to admit and release themselves?

A. Yes.

Q. I thought, Dr. Sugar, that you had testified earlier that adolescents, 15, 16, 17 or 18 ought to be allowed to admit themselves with a psychiatrist's evaluation.

A. Yes, I did. Excuse me. I had a lapse in what you were saying.

Q. What is your opinion then? Should they or shouldn't they?

A. They should be allowed to admit themselves if the psychiatrist agrees that they need admission.

Q. So then what you testified to Mr. Roth then was incorrect?

A. I testified to the same thing.

Q. Well, I believe the record will show that you testified that they should not be allowed to admit or release themselves.

A. I said they would be allowed to release themselves. I said if they need to be admitted and they present themselves at a facility and they say "I am disturbed, I want help," and the psychiatrist concurs in making the diagnosis and he suggests (99) an admission would be the best course, then they should contact the parents and then the procedures should be arranged for the youngster to be admitted.

The youngster has a right to say "I hurt," and then somebody responds. So, the psychiatrist, if he is the first one, he makes a diagnosis and then he contacts the parents or guardians and they take—

Q. Suppose the parents don't agree?

A. I took up that point earlier with Mr. Roth.

Q. What is the answer if they don't agree?

A. The physician has the choice then of contacting the law to institute proper proceedings; to admit this youngster because he is a danger to himself or others.

Q. In terms of your expert opinion on what the law should provide, the law now provides that people above the age of 18 may make applications to mental institutions. Do you feel that children between the ages of 13 and 18 ought to be allowed to make that application understanding that after the application there will be an examination?

A. I think I just answered that question.

Q. Do you feel that they should be allowed to make that application?

A. I think I just answered that question.

Q. Can you answer my question?

MR. ROTH: I object.

(100) BY MR. FERLEGER:

Q. Do you feel that children between the ages of 13 and 18 should be allowed to make application to an institution?

A. By "application," what do you mean?

Q. Under the statute that you are familiar with.

A. I want to know exactly what you are referring to when you say "make application".

I just answered the question of the youngster if he is disturbed and he presents himself at an institution or a psychiatrist's office and says "I am upset. I want to be in the hospital."

Then the psychiatrist may make an evaluation and then follow the procedure I just mentioned.

Does that answer your question?

MR. ROTH: I object to this on the basis that Dr. Sugar has already replied to the Act and indicated that parents admit their juveniles up until 18 and has indicated when you tried to question and indicate whether or not he was saying juveniles should be able to apply for admission. Dr. Sugar responded to that by saying no, that juveniles, if they need help, can seek help, but the application still goes through the parents.

I can't understand why you are harassing him with this question four or five times.

MR. FERLEGER: He has testified in both directions (101) on this question.

MR. ROTH: He has not.

MR. FERLEGER: He said himself that he misspoke.

We are talking about the word "application".

THE WITNESS: Does that clarify the fact that I do not understand what your question was and that, therefore, I corrected it?

BY MR. FERLEGER:

Q. Dr. Sugar, we are talking about Section 402 of the Mental Health Act.

The word "application" is used in that section. That section states: "Application for voluntary admission to a facility for examination, treatment and care may be made by (1) any person over 18 years of age."

For people under 18, we understand the provisions are the parents or the guardian and that they have to make the application.

MR. ROTH: Or individuals standing in loco parentis.

BY MR. FERLEGER:

Q. After the application then comes the examination.

My question is, and this has not been asked before at all: Is it your expert opinion that that application should not be allowed to be made by a person between 13 and 18 or should the person between 13 and18 be allowed to make that application?

(102) A. What does "application" cover?

Q. Application is a request to the institution to admit and/or examine.

A. I just said that he could make application.

Q. The reason—

A. Excuse me. I am going to have to be getting back. I would like to have some idea of where we are in terms of completing.

Q. I probably have another 20 minutes or so.

The reason that I wanted to clarify that is because the Complaint that you have read, that the plaintiffs have filed, are asking that people below the age of 18 ought to be permitted to make that application.

A. Well, if it is in the law already, how can there be a complaint?

Q. It is not in the law, and the law states that people below the age of 18 cannot make an application.

A. I see.

Q. You have testified for some people below the age of 18 that they ought to be allowed.

A. Okay.

Q. Now, Dr. Sugar, in the past year or so can you tell us how many occasions you participated in a judicial proceeding for a mental health commitment?

A. In the past year?

Q. Yes.

(103) A. I really don't know offhand.

Q. Can you estimate?

A. Very few.

Q. More than five?

A. No.

Q. In the past five years, what has been your average number?

A. I do very little hospital work. I have participated in this very little in the last few years.

Q. When was the last time, if ever, that you worked as an institutional psychiatrist?

A. I have worked in institutions and I have been a consultant to a variety of institutions, and I still am.

Q. When you state "I do very little hospital work," what do you mean by that?

A. By that I mean direct, primary care being the responsible physician for the immediate day-to-day care of the individual.

Q. When was the last time, if ever, that you had responsibility for direct, primary care in an in-patient facility?

A. Yesterday. The day before yesterday.

Q. How many days of the past year have you been involved in that?

A. Perhaps a week.

Q. So it is correct that your main experience does not involve such?

(104) A. My main recent experience involves office practice rather than hospital practice.

Q. When was the last time that your major responsibilities involved hospital practice?

A. I just told you, the day before yesterday.

Q. Has there been a period of time during which you have been involved as a hospital physician rather than an office physician?

A. I think that I'd better clarify what I am saying.

In my private practice—I at one time did a good deal of hospital work as well as office psychiatry.

In recent years I have not been doing very much hospital psychiatry. In other words, I treat my patients in

the office. If they are manageable for treatment, I treat them in the office. If not, then I refer them to someone else.

Q. You said "at one time". How long ago was that?

A. Oh, some eight years ago, I guess. Maybe 10 years ago.

Q. Now, Doctor, you testified at the end of a long question from Mr. Roth during which you read Section 406 of the Act, and you felt that those procedures would be bad for children. Those procedures required notice and a hearing and counsel and all that. Is that your opinion, Doctor?

A. If I rendered it a few minutes ago, I think that states the facts for something.

Q. And the reasons that procedure would be bad includes the trauma of a judicial proceeding and the other factors that (105) you mentioned earlier?

A. I stated my reasons earlier.

Q. Now, can you explain why those procedures should occur under the regulations which Mr. Roth referred to because those regulations, you know, require that when a juvenile objects that all these 406 procedures that you just testified are bad be followed through.

A. He was already under care of a psychiatrist and in the hospital. He is in an institution where some controls are offered and treatment is going on. He is in a safeguarded situation of a medical facility to look after him. So, when he is having a hearing, that isn't in that kind of context.

Q. The hearing in court would be before a judicial officer?

A. But he is essentially in a hospital and—the hearing may sometimes be held in the hospital.

Q. So the difference is that the juvenile is already in the hospital and at that point you feel that the Section 406 procedures are okay or at least not objectionable?

A. He is getting treatment. He has had the recommendations of admission and treatment and already started on that.

Q. How long does that usually take, those recommendations and decisions to begin treating? How long after institutionalization?

A. Well, once he is in the hospital that is part of the treatment.

(106) Removal from the home—removal from the home for any adolescent is treatment in and of itself. It takes him away from some pressures at times that they have within the family or within their neighborhood or wherever the problem may be.

Q. But hospitals also offer individualized treatment; is that correct?

A. Yes.

Q. How long after institutionalization would they typically begin?

A. I am pointing out the treatment is already under way when the individual is in the hospital.

Q. But I am talking about the additional individualized treatment.

A. I have no figure to provide for that.

Q. Usually it takes more than a couple of days, doesn't it?

A. It may be the same evening. It may be the next morning. There is no usual kind of figure that I can provide you with.

Q. Now, Doctor, you testified about this revolving door idea that if juveniles could institutionalize themselves they could sort of go in and then request to leave and then if they got out could come right back in again.

I want to check whether or not that it is still your opinion because you have now testified that juveniles should be allowed to apply for institutionalization on their own. (107) If juveniles would be, as you wish them to be, allowed to apply for their own institutionalization, would we still have this problem with them going in and out?

A. I think I clarified that point in my earlier testimony that if they do apply, they are admitted. Then they should be admitted to stay for as long as the psychiatrist needs them there.

Q. But the Pennsylvania Mental Health Act for voluntary commitment doesn't allow that, does it?

A. Possibly.

Q. You testified that you are familiar with the voluntary sections of the Act. As a matter of fact, you testified that that is the main part that you are familiar with.

A. I did not say I was an expert on Pennsylvania Law. I said I read it.

So now if you are making a point about some aspect of it, I would appreciate you clarifying what you are discussing.

Q. First let me get your position. Your position is—

MR. ROTH: Why don't you first explain it. Let me object at this point. He is being misled.

MR. FERLEGER: I will do my best to be as clear as I can.

BY MR. FERLEGER:

Q. Your position is if a juvenile is allowed to admit himself or herself that it should be for as long as the psychiatrist (108) deems necessary; is that your testimony just now?

A. Yes. It should be on the basis of a psychiatric evaluation for admission.

Q. Now, for voluntary admission in Pennsylvania, the law, for your information, provides that under Section 402 a person can leave at anytime; and under Section 403 the commitment can be for no longer than 30 days with a provision that the person can give notice and then leave after 10 days, so those provisions would not satisfy what you see the needs of juveniles to be; is that correct?

MR. ROTH: This is an incorrect interpretation.

MR. FERLEGER: We will take a minute and let the doctor read the statute.

THE WITNESS: I really am getting tired. I think there has been a lot of redundancy in the questions that I have been asked, and I would like to take a break for coffee.

MR. FERLEGER: That's fine with me.

(Whereupon, a short recess was taken at 12:12 o'clock P.M.)

(Deposition continuing at 12:24 o'clock P.M.)

BY MR. FERLEGER:

Q. Doctor, with reference to this signing in and out of institutions, I believe the last question that I asked, which was not answered, was whether it was your opinion

that the voluntary commitment provisions of the law would not be appropriate for (109) juveniles since they do not allow what you said is the right procedure for the commitment to be as long as the doctor wants.

Is it your opinion then that the Pennsylvania voluntary sections would not be appropriate for juveniles?

A. I don't know what your question is yet since the question seems to be escaping me.

Q. Let's break it down into parts.

A. You're asking me to render an opinion about law in your state, and I'm only here to render an opinion about psychiatry.

Q. I am not asking you about an opinion about law.

You stated that it was your opinion that when juveniles, let's say, between 13 and 18 sign themselves into an institution or make that application, which you are in favor of, that that should be for as long as the psychiatrist thinks it is medically necessary; is that right?

A. And you told me that is the law.

Q. Is that right?

A. I said that a youngster should be able to tell somebody he is distressed, in pain and needs to be admitted, and then if that person is a psychiatrist that person should contact the parents or the guardians to take the proper procedure for admission. If the parents object and don't want the youngster admitted and the parents refuse to cooperate and the psychiatrist feels it is necessary, then he can call on the law to act in loco parentis.

(110) Q. And beyond that it was also your testimony that a child between 13 and 18 ought to be allowed to make the decision under Section 402 and 403?

A. By "application" I meant what I just said.

MR. ROTH: I have an objection on the basis that I don't think Dr. Sugar fully understood what you meant by "application" as far as the juvenile making the application or, as he stated numerous times, that if the juvenile is in need, then he should be able, the psychiatrist, after the evaluation, he should be able to indicate to the parents or guardian that an application should be made.

I think there has been some confusion with that, and that is what we are trying to clear up.

MR. FERLEGER: Well, we read the section of the Mental Health Act defining "application" and describing it, and Dr. Sugar—

MR. ROTH: I think he has clarified that point.

MR. FERLEGER: Well, your testimony is that if the juvenile's parents agree, then the juvenile should be allowed to get himself admitted with the psychiatrist's agreement to an institution; is that correct?

MR. ROTH: I object to that. He has not said that at all.

THE WITNESS: Well, I think you are misunderstanding and you are misphrasing what I just finished saying. I have (111) said it at least six times today.

BY MR. FERLEGER:

Q. And at six different ways.

A. No, I have not. I have said it explicit each time. I think this is unnecessary.

MR. ROTH: I object.

BY MR. FERLEGER:

Q. The Mental Health Act allows application to be made for admission to an institution by any person over the age of 18; for any person under 18 that application has to be made by other people.

MR. ROTH: That is exactly what I have just finished explaining, and I think you are asking a redundant question.

I object.

You are harassing the witness.

BY MR. FERLEGER:

Q. For people under 18, should that application—can that application, in your opinion, be in the best medical sense made by the juvenile himself?

A. I think I have just answered your question.

I refuse to answer your question again. I think it is in the record. If you want to read it, fine. I don't think I need to be going over the same ground again.

Q. Now, you testified to Mr. Roth that there would be a (112) problem if juveniles could admit and ask for their own release. There would be a problem with them going in and out of the institution; is that your testimony?

A. I said that if there were no psychiatric evaluations, this is not suitable.

I just finished clarifying that a moment ago that it had to be on the basis of psychiatric evaluation, diagnosis, recommendation; not on the basis of the juvenile being his own doctor.

I think I said that explicitly just 20 minutes ago.

Q. If there is an evaluation, do you feel it would be anti-therapeutic to allow the child to request to leave

when the psychiatrist's opinion would be that he or she should stay; is that correct?

A. Yes; but there is the availability of the law to have a hearing.

Q. Don't we have that same anti-therapeutic effect when an adult voluntarily requests to leave and the psychiatrist is in opposition?

A. Yes. The patient still goes out quite disturbed if he is not ready to leave yet.

Q. Now, Dr. Sugar, you testified with regard to operations in medicine or surgical procedures or physical problems that the child may understand and would be frightened, but that even if the child doesn't want the procedure that it should just be up (113) to the parents and the doctor whether or not the child gets the procedure; is that your testimony?

A. That's what I said.

Q. Are you aware at all of any legal provisions or limits which make it impossible for parents and doctors acting without regard to getting permission from the Court to make it impossible for them to decide on medical operations or surgical operations for children?

A. You're asking me for a point of law.

Q. I am asking you whether or not you are familiar with any legal principle which operates to limit the right of the parents to decide with the doctor as to what operations their children should get.

A. You're talking about ethical procedures or unethical procedures?

Q. I am talking about whether or not you have heard of any such legal principles.

A. I think you'd better clarify what you are asking me about.

Q. Have you heard of any such legal principles?

A. Can you clarify that?

Q. The legal principles I am talking about are those principles which prohibit or limit the right of parents acting with doctors to decide in their sole discretion what medical or surgical procedures are performed on children.

A. Where does that apply?

(114) Q. Excuse me?

A. Where does that apply?

Q. I don't understand your question.

A. Well, I am just rephrasing it to ask you to clarify what you are asking me.

Q. It applies to the situation where there are medical or surgical procedures which are contemplated.

Are you familiar with any legal principles in that regard?

A. You're asking me for a point of law—

Q. I am—

A. —and not medicine.

Q. I am asking you whether you are familiar, whether you have heard of any of those legal principles.

A. I have heard of situations where a youngster needed a tranfusion and, because of the parents' religious feelings, they would not. They would let the child die, and the Court would step in and have the medical procedure that was designated, the approved ethical procedure.

Q. Now, in a situation where an adult is advised in a medical, surgical context where an adult has advised that he or she needs a certain procedure done, and where it is not a question of life or death, it is true, isn't it, that the parents could refuse that procedure?

A. You are talking about an adult wanting to not go ahead (115) with the procedure that has been recommended?

Q. That's correct.

A. And you're asking if he has the right to refuse?

Q. In your medical judgment, what is your opinion?

A. Yes, he has a right to refuse.

Q. Even though one or two or 20 doctors may explain that it would be best to have that?

A. He has the right to refuse.

Q. Now, if that adult is told by one or two or 20 psychiatrists that the best medical procedure would be for him to be institutionalized, is it also your opinion that he has the right to refuse?

A. That is a question where the patient may not be capable of exercising proper judgment.

If you are talking about a physical condition and the assumption is made through the inference that the patient has his proper faculties for judging the situation and he refuses, it is a different situation from the very condition that needs to be tendered to as the one that is impairing his judgment and thinking processes. Then he is not in a position to exercise proper judgment about his condition and the need for treatment for that condition. So, it is not comparable to the physical situation.

Q. Is it your position that in a situation where a doctor counsels a certain surgical or medical procedure to be performed (116) on a chiid and with the parent agreeing that that should be outside the scrutiny of the law?

A. In the ordinary circumstances, yes.

Q. So, for example, if a young child had a healthy kidney which his parents and the doctor felt could be transplanted to another child who needed a kidney, is it your opinion that that removal of the organ should be just between the parent and the doctor?

A. That is not the ordinary circumstance.

Q. What is your opinion?

A. I would not render an opinion. It is outside of my field and specialization. I don't do kidney transplants.

Q. Well, you have rendered opinions about other medical procedures. Why is it this one that you decide not to render an opinion on?

MR. ROTH: Objection.

He has not rendered an opinion as to medical procedures. He has rendered opinions in terms of need and emergency for a condition that so warrants it.

MR. FERLEGER: I don't understand that.

THE WITNESS: I think what you are talking about is beside the point. I do not render opinions about medical procedures.

BY MR. FERLEGER:

Q. I agree that the medical procedures are beside the point.

(117) Mr. Roth brought them up in the questioning of you.

A. I was talking about these procedures that you are talking about of a kidney transplant being done on a child without his understanding and just because the doctor said so—that is not an ordinary circumstance.

I have already clarified my point. You are asking me to go into detail about a condition which is not in my area of specialization.

Does that clarify my comment?

MR. FERLEGER: No further questions.

MR. ROTH: I have no further questions.

MR. FERLEGER: Just for the record, since I came after Mr. Roth started the deposition, because I was later than I expected to be, I have not agreed to any stipulations with regard to signing or certification or filing or objections, and reserve the right to make any objections before the testimony is introduced.

MR. ROTH: You might want to show for the record what time the deposition began and what time it stops.

MR. FERLEGER: And the fact that Mr. Roth knew that I would be late.

MR. ROTH: By ten minutes, when he was late by 35 minutes.

MR. FERLEGER: I don't know of any proceedings in (118) the rules which allow counsel to begin a deposition without the other side being present.

MR. ROTH: Well, my understanding of the rules is that you are invited to attend, and the time is set forth, and as a result, we questioned Dr. Sugar about his qualifications and history and then the questions were read back to you prior to getting into the substance of the deposition, so we feel there was no prejudice whatsoever.

(Whereupon, the deposition concluded at 12:38 o'clock P.M.)

Reported by:
Marvin Dinter
Official Court Reporter

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Dr. Max Sugar

Dated:

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

Civil Action No. 72-2272

Kevin Bartley, et al,

Plaintiff

vs.

Haverford State Hospital, et al,

Defendants

DEPOSITION OF DR. JOEL S. FEINER, M.D.
Philadelphia, Pennsylvania
August 21, 1974

Oral deposition of DR. JOEL S. FEINER, M.D., held on August 21, 1974 at the office of DAVID FERLEGER, ESQUIRE, 1315 Walnut Street, Philadelphia, Pennsylvania commencing at 2:00 p.m., before Michael H. Stephany, Approved Court Reporter.

Appearances

For the Plaintiff: David Ferleger, Esquire

For the Defendant: Barry Roth, Esquire, Room 323, Health and Welfare Building, Harrisburg, Pennsylvania 17120

(2) DR. JOEL S. FEINER, M.D., having been duly sworn, was examined and testified as follows:

Examination

BY MR. FERLEGER:

Q. Dr. Feiner, what is your occupation?

A. I am a Physician-Psychiatrist by speciality, Child Psychiatry by sub-speciality.

Q. Where are you employed?

A. I'm employed by Mott Haven Unit of the Lincoln Community Mental Health Center at the Albert Einstein College of Medicine.

Q. What city is that in?

A. Bronx, New York.

Q. Will you please tell us where you received your medical and psychiatric training?

A. After I went to college at Yale University, I received my M.D. at Albert Einstein College of Medicine. In 1964 I was a Pediatric Intern at Bronx Municipal Hospital Center, and took my residency in Child Psychiatry Fellowship at Bronx Municipal Hospital Center of the Albert Einstein College of Medicine. Completed my training in 1970.

Q. Since then have you been involved in any academic work involving Child Psychiatry or related fields?

A. Since that time, I have been both a service provider, (3) working with children and adolescents in the Lincoln Hospital, Department of Psychiatry and a faculty member of the Albert Einstein College of Medicine, currently holding the rank of Assistant Professor on a full-time academic faculty.

Through the years 1972 to 1974, I held a career teaching award recommended by the National Institute

of Mental Health. I understand that I was one of two recipients of that award from the country.

My work during these two years was to teach in the areas of community Child Psychiatry, which I proceeded to do, for a variety of personnel from medical students to psychiatrists in training, social workers, et cetera.

Q. Have you delivered any papers with regard to children or child psychiatry?

A. Yes. I delivered a number of papers concerned with adolescent phenomenon, particularly related to those phenomenon observed in the South Bronx area that I have worked. I have talked about street gangs in the South Bronx and graffiti phenomenon. I have also talked about children in the context of their schools, recently having delivered a paper at the American Ortho-Psychiatric Convention in April, 1974.

Q. Does your work involve treatment as a psychiatrist of children with emotional problems?

(4) A. Yes, it does.

Q. And also families of children with emotional problems?

A. That is correct.

MR. FERLEGER: Could this be marked as Plaintiff's Exhibit No. 1, please?

(Curriculum Vitae marked as Plaintiff's Exhibit No. 1 for identification.)

BY MR. FERLEGER:

Q. Dr. Feiner, could you identify Plaintiff's Exhibit No. 1, please?

A. Yes. That is a Curriculum Vitae which I have submitted.

Q. This is your resume?

A. My resume.

Q. And this resume includes your academic appointments and professional activities and papers and a review of your experiences?

A. That's right.

MR. FERLEGER: Will you please attach to the deposition that so we won't have to go over the rest of your qualifications?

BY MR. FERLEGER:

Q. Dr. Feiner, can you please give us a brief review of the kinds of emotional and psychiatric problems that children have (5) and then have those problems fit in with their relations with their families and other social agencies?

A. Well, the vitae is enormous, and ranges from everything from severely withdrawn and clearly psychotic children, who are virtually unable to relate to other people to the kinds of problems which we would consider to be situationally based. There are problems which result from the non-supportive nature of a particular environment, the inability of the environment and the child to mesh in a way that is conducive to the child's development. In between there are a variety of problems, various degrees of severity. What I, and any others certainly in the past five years have become extremely aware of is the relationship of a child's behavior and really his psychiatric symptoms to the entire context of that child's life. The usual context is the child's family, and what we talked about in recent years is rather than the kind of diagnostic approach where a child is diagnosed quite apart from the context of his life, and really in a kind of one-to-one interview. We are now very concerned with looking at the child from what we

might call an ecological context, taking into account all of the factors in the child's life, what that includes is recognition of the fact that children are extremely responsive to what goes on in families.

(6) Perhaps the most responsive element to the child's communication is hidden agendas, overt and covert needs of all of the members of the family, and since the early '40's we have known that parents can induce certain types of behavior in children based upon their own unconscious needs.

I guess a very simple analogy might be for the need to have a child behave in a particular way might be the need that is commonly recognized, for example for the public to go to football games or boxing matches. It is often said that this is an outlet, and it provides—it serves the need for people to funnel off some of their aggression, some of their excitement, much in the same way one might suppose that this need is ongoing, and a child is often the most easily available person to continually act out for the parents.

Another example of this would be the following—there certainly are certain families where the parents are simply not responsive to the usual kinds of—one might say good behavior or positive behavior. That behavior is simply ignored not acknowledged, and a child is not—does not receive any attention for that behavior. All of us need attention, and a good part of our life goes into ways in which we can receive attention from important people, and so a child finds ways that this attention is forthcoming, and very often that is what is (7) so-called bad behavior.

Q. Does that include behavior that in other context might give you this delinquent behavior?

A. That's right.

Q. So that a child's emotional problems or the stresses in the family situation could result in children acting in ways that might be considered delinquent or criminal as well as traditional mental health type systems?

A. Absolutely, and we might say after moralistically that bad attention is better than no attention at all.

Q. From the child's point of view?

A. From the child's point of view.

Q. Dr. Feiner, are you aware of any commission or any other psychiatric reports on the needs of children that have any conclusions that relate to the kinds of problems that you were just discussing?

A. Yes. There is, in recent years, a very important commission called the Joint-Commission on Mental Health of Children, and I have a rather extended quotation from a section of that that I would like to read. It is from the report of Task Force-2, which is "Studies of Children from Kindergarten Age through Eighth Grade." It is in the Joint-Commission on Mental Health of Children, Mental Health from infancy through adolescence published by Harper and Rowe, New York, 1973. This (8) is pages 112 and 113.

Q. But Dr. Feiner, is that report considered an important one in the field of Child Psychiatry?

A. Yes. It is an important one and one which has been widely discussed and written about in various sources.

Q. Doctor, do you have a copy of that report?

A. I don't have a copy with me.

MR. ROTH: Pardon?

THE WITNESS: I don't have a copy with me.

MR. ROTH: Where is it actually located?

THE WITNESS: It is located in any library which contains psychiatric references.

MR. ROTH: May I just register an objection on the basis of his reading it without seeing a copy of the report prior thereto?

BY MR. FERLEGER:

Q. Will you please read us the quotation that you have?

A. The quotation is as follows:

"The intervener ought to recognize the close interrelation interrelationships between the individual and his surroundings and deal with the factors that impinge upon the individual from the outside as well as from within the individual himself.

When the surroundings are not taken into account, there is, (9) for example, insufficient understanding of the social conditions of diagnosis, that is that psychiatric labels tend to stigmatize."

It goes on "All of these children are plunged from their natural environments and introduced to a different setting for a cure. If the child is treated successfully in this new environment, it is assumed that he can be sent back to his old environment to make a clean start. Unfortunately, however one could not remove psychopathology like an appendix. This traditional approach disregards the unfortunate fact that children often tend to conform to the niche in which they have been placed. A child labeled 'delinquent' may begin to consider himself a delinquent, and act accordingly. Furthermore, if the environ-

ment to which the cured child is returned has remained the same or perhaps even organized itself more firmly around old lines of interaction with the absent child seen as the only 'family problem', it seems highly unrealistic to expect the child to maintain this cure in the face of re-exposure to the elements which caused his disturbance."

Q. But Dr. Feiner, do you agree with those observations which you have just read?

A. Yes, I do.

(10) Q. And you would adopt them as your own?

A. I do try to put them into the practice of my own work.

Q. Dr. Feiner, from what you have said, I understand that there might be situations where the family's problems might result in the institutionalization of children; is that the case?

A. Absolutely.

Q. How would that happen?

A. Well, that would happen in a number of ways. The family is under stress from a number of different sources, often there are some intercurrent tragedies, such as separations, deaths, illnesses and the child, as part of that family is also under the stress. The child—everybody in the family experiences anxiety in different ways. The child's anxiety may be expressed dramatically, in which case the family, being overwhelmed to begin with, feels that their lot may be somewhat better if the child is simply out of the picture for a while. It is often very likely that under circumstances of stress, families will approach—what they consider experts, professionals of some sort or another, physicians, school personnel and so on and ask for some help, whereupon the advice that they get is that the child should be hospitalized.

They reluctantly follow that advice, feel guilty as a (11) result and the snowball effect continues as the family does not ultimately really receive help for its problems.

Q. Well, why would it be the child that would be scapegoated or institutionalized rather than another member of the family?

A. Well, the child is quite susceptible, and often it isn't the child—I mean there are many situations where the child does not go on, but the child has some intrinsic vulnerability based upon the fact the child is dependent to begin with, the child is more controllable in certain ways, the child is also often a newcomer to the setting, the last to be present in this little system, often unwanted, and un—not chosen.

There also is the important fact that children do represent for the adults a replay of their own childhood, and a re-experiencing of their own problems when they were children, so that the child is—the repository of the projected bad feelings of some parents towards their own childhood.

Q. So that the result in parent misunderstanding, the actions or feelings of the child?

A. Absolutely. Absolutely. I mean I would go on to say that this is certainly not unusual for parents to misunderstand or act in ways that are inappropriate towards their children.

Q. Well, do you feel, then that parents can be relied on to act in the best interests of their children?

(12) A. Well, I am sorry to say that the increasing statistics about child abuse and child neglect, the overworked bureaus of Child Welfare, I think speak to the point that parents do not always act in the best interests of their children.

I can recount tragic cases where that simply was not so.

Q. Now Dr. Feiner, the orientation of psychiatry that you have been discussing, has that always been the orientation of psychiatry or is that a recent change in the past 10 or 20 years?

A. Well, it is really within the past 10 years. There has been an increasing attention paid to the—what we might call the context of children's lives or the ecology of their lives, and this is so in part because we have just become technically more proficient as understanding group behavior and family behavior, and we now recognize how that behavior can be looked upon rather than isolating one element of that situation and assuming that all behavior and all symptoms are somehow self generated.

Q. Dr. Feiner, are you familiar with and have you examined the deposition in this case of Dr. Max Sugar, of Louisiana?

A. I have looked at some of it, yes.

Q. Now, not with reference to his entire deposition, but only with reference to those parts examined discussing his general (13) orientation in child psychiatry, how would you place him in terms of this change in orientation that you just discussed?

A. Well, I would say that he takes a traditional point of view, which isolates a child from the environment and discusses the child's behavior and symptomatology in very specific individual terms.

Q. By "traditional" you mean that orientation would be prior to the developments of the last 10 years?

A. Right.

I would also say, if I might that there is, in his testimony a kind of—what I would consider an inappropriate

sense that institutions can be taken for granted, that parents, schools, police and so on are institutions of good will. I wish that that were so, and maybe 20 or 30 years ago it was felt to be so in general ways.

Our experience certainly working in poverty neighborhoods is simply that these institutions cannot be taken for granted; that, as I have mentioned, parents do abuse and neglect their children and schools often do not even fulfill the mandate of teaching their students, let alone are they able to evaluate behavior.

Q. Dr. Feiner, you mentioned working in poverty neighborhoods. Now, in terms of the social class of children who are likely to (14) be institutionalized, what class would that be?

A. It very often is children of lower class—

Q. Is it correct that in terms of the various state hospital systems in the country, that it is more likely that lower class or lower middle class are patients there rather than the upper class?

A. It is my understanding that that is so, and in fact that often—the professionals who do the evaluations are at some great distance culturally, class wise and geographically from the situation in which these children are living, and misperceive behavior.

Q. Dr. Feiner, will you please tell us the general effects of institutionalization in mental institutions and especially how they may affect children?

A. Well, institutionalization is an extremely serious matter, especially mental institutionalization, extremely serious. First of all, there are no good studies, to my knowledge that really long range benefits are achieved from treatment. That, traditionally upon re-emergence into the community children are often, as I have said earlier, placed

in the same circumstances which they left, and the mental hospital has either done a sequestering of them from the real problems of their lives or an opportunity to participate (15) in some unreal world. Also the fact that problems have been dealt with by hospitalization has—is very often a first resort solution establishes mental hospitalization as an ongoing way that people should deal with their problems or that this child should deal with his problems in the future. Certainly we have to be very aware that there is a stigma that remains to mental hospitalization, and that a child at some point in his life will have to apply for licenses, have to apply for jobs, will have to account for this period of his life in some way, and we know that the reality is that the public does not look upon mental hospitalization as a benevolent benign situation.

The family is often stigmatized, and feels guilty as a result and looks, then for this person to behave in similar ways. After all, a mental patient, in our society is someone who has been in a hospital, someone who is psychotic and not in a hospital is not considered a mental patient. The operational definition of a mental patient is someone who has been in a mental hospital, and that brings with it certain expectations of the people around; moreover hospitalization sometimes obscures the kinds of permanent and environmental issues that I mentioned, it just tucks them away, and may never deal with them, and one may often get one child hospitalized (16) for family reasons, and then low and behold the family classes the next child in line in the family to start to deal with its problems.

Q. Has that happened in your experience?

A. Yes, it has happened.

Q. So that once one child in a family is institutionalized, you wouldn't be surprised, if, after a period of time,

the next child develops some problems and becomes institutionalized?

A. It has happened in my experience, when the family has not been dealt with.

Q. Dr. Feiner, it seems from your testimony, then, that you consider treatment by physicians in mental hospitals to be somehow different than treatment for physical problems of children in community or even in a general hospital such as a tonsilectomy or some disease that requires hospitalization in a regular hospital?

A. Well, I do, because if one were to bring a child with tuberculosis to a doctor—and this is really a similarity, in a way, one would test all of the people in that family for tuberculosis and treat them, if one found tuberculosis. I feel that taking a child to a psychiatrist for treatment is different in part because there are qualities of this child having a contagious disease that needs the entire situation, as I (17) mentioned previously, that needs to be looked at, and the response of the environment or of the psychiatric institution has many alternatives.

Q. Dr. Feiner, since this lawsuit involves an attempt to attain judicial hearings to explore alternatives to institutionalization and the needs for institutionalization, are there alternatives for treatment of children who need mental problems that a court could explore or is hospitalization the only possibility?

A. No. There are alternatives that I would expect ought to be used even before it gets to a court. These are by now tried and true situations.

I will refer to one of them which is a study called "The Treatment of Families in Crisis." In the results reported in this book, which is by Drs. Donald Langsley and David Kaplan, 75 patients who would normally be admitted to a hospital were matched with 75 controls, all of whom were admitted to hospitals according to usual procedure. The 75 patients who were treated in a family context with intensive rapid intervention of a variety of various ways showed 85 percent less hospitalization over 6 months than those who would have been hospitalized in the regular way. This saved all of the problems of being hospitalized and is a dramatic way of (18) relieving stress in a family and working in a problem oriented way towards the supportive and human and quite appropriate resolution of family problems.

After all, the family often comes in in panic, has—they have exhausted their own repertoire of behaviors and solutions, and often it is common in and of itself for someone to say "Calm down, I think we will be able to help, let's see what the problem is. Maybe all you need is a good night's sleep, which I can help you have, and let's talk about it and see what resources are available." This worked initially in 75 out of 75 and then over 6 months only 17 percent of those 75 had to be hospitalized.

Q. Now, is this an accepted alternative, then, without hospitalization?

A. Absolutely. It is an accepted alternative which requires a vigorous effort on the part of mental health personnel.

Q. Now doctor, the calming effect that you just described reminds me of Dr. Sugar's testimony where he testified that when a child is brought into an institution, a mental institution, there is very often a sudden, you know, relief of stress, and the child—almost says—feels good to be there. Now, is there any other explanation besides the beneifts of hospitalization that might explain that relief?

(19) A. Well, in an ironic way that in part may speak to the situational nature of the child's problems—that the child hasn't gotten any therapy yet, there hasn't been any internal reorganization of his character structure, he just has had a situational environmental manipulation, and what I am suggesting is that can be done while the child is still there with an objective parent, who is human and sensitive to the needs of this family, and I would say that calming effect could in fact be just a non-specific relief that somebody is doing something about a situation.

Q. Dr. Feiner, most often—and you can confirm or deny whether this is actually true, but it appears to me that most often psychiatrists to whom parents bring their children or parents are directed to bring their children learn of the symptoms and the background of the behavior of the children from the parents, and I wondered if you could discuss, as you have peripherally earlier, whether or not parents are reliable sources for that sort of information?

A. Well, I am not sure that anybody who is experiencing tremendous anxiety is reliable for this source of information. I think that they, too, are very much in the situation and obviously can't be objective reporters of the situation. Clearly what they have to say is important—I wouldn't deny (20) that their information is important, if not crucial; however, it is only one of the part of the whole thing. Very often we see a child, mental health professionals will see a child on one occasion and make an evaluation that really needs to be thought about, because a child is going to be either overly anxious and show behavioral manifestations or withdrawal, because of the unfamiliarity of the setting, the kinds of feelings that the child has that this interview is going to determine the child's fate for a good period of time, and there is no sense that this—that

this situation is in the child's best interest. So likely what a psychiatrist would observe is artifact, to some extent.

Q. So then the kind of brief evaluation that patient or potential patient would get, as under the state's regulations and the statute involved here, either at the hospital upon admission or by a referring agency, that kind of examination might not be the best way to really find out what is happening with this child?

A. It might not be the best way.

Q. Now doctor, there is some dispute in this case as to who should determine the facts involved in a particular child's situation. In other words if the child is accused of behaving in a certain way, if that is true, it might mean one thing to (21) a psychiatrist, and if it is not true it might mean something else. Now, do you feel that psychiatrists are social agents who are best qualified to make those kind of judgments or should it be a judicial or other sort of thing—partial agency?

A. Well, I think that when it comes to the point of determining facts for the purpose of making major and dramatic alterations in a person's life, that we need help, that we are—the facts that we are used to gathering are often the psychological facts which require some interpretation and some subsequent validation. We do not always have the access to the facts, although in some contexts, such as crisis intervention were, we try to get it by immediately making home visits, by immediately going to schools, by trying to gather as much information as quickly as we can, but we are really taught to evaluate emotional experience, which often is the person's interpretation of the outside world, and not the outside world itself.

Q. Doctor, from what you have said, and based on your professional experience, do you feel that for children

19 years of age and under that a pre-commitment hearing to determine the need for hospitalization is appropriate?

A. Well, let me say, if it comes to that, it is appropriate. (22) From my point of view it would certainly would be that there are many things to be tried first, and many ways of responding to paying, and—but if it comes to that, it certainly is appropriate.

Q. Doctor, do you feel that a requirement by the law that there be a pre-commitment hearing rather than parents being able to apply for institutionalization that that requirement would encourage psychiatrists or parents to explore those alternatives?

A. I would certainly hope that it would, that this would underscore the serious nature of hospitalization and cause people to have second thoughts, and to search out various alternatives such as one that I have mentioned earlier.

Of course there are others.

Q. Now Doctor, can you explain why, for both the children involved and for the family a judicial hearing might actually be therapeutic or beneficial?

A. Well, I think if it reaches that point, it is very likely that the child—if the child is the one that is refusing the hospitalization is feeling rather helpless and hopeless, and feeeling rather abused, and unable to turn to anyone, I would say at this point, being very crucial that the child have a Advocate to diminish the possibilities of the hopeless and (23) helpless feeling. After all, an important reason why many children set up, set out, and do whatever they do that may have caused them to get into the hospital is because they feel hopeless and helpless, and to be forced into a situation in a similar way is reinforcing this feeling. Then, if they get into the hospital in this situation,

they have been coerced, and it is extremely difficult to treat anybody who is being in treatment under all the mayhem or coercion.

Now, for parents they often are hospitalizing the child because of other people's suggestion, and ongoing support for this procedure. It may in fact be very supportive for them to submit the situation to an independent kind of evaluation, which would then relieve them somewhat of the subsequent feelings of guilt that they may have.

Q. And that independent evaluation could be the testimony of a psychiatrist before someone appointed by a court or a court and an airing of both sides of the story?

A. Yes.

Q. In the courtroom?

A. Yes.

Q. Dr. Feiner, have you read the Pennsylvania statutes that are involved in this case?

A. Yes, I have.

(24) Q. And have you read the regulations recently promulgated by the state regarding conditional safeguards for children?

A. Yes, I have.

Q. Do you have a copy of those regulations with you there?

A. Yes, I have.

Q. These regulations are the regulations that I published in the Pennsylvania Bulletin, Volume 3, number 37, page 1840 and they are part of the record of this case with reference to these regulations, which only apply in some parts to children between 13 and 18, do you—will you please comment on the appropriateness of the notice to children of those ages which are read to them. Do you feel that that notice is likely to be understood by children or misunderstood?

A. Well, I think for two reasons, essentially it is likely to be misunderstood. One it will be read to a child when there will be many other things on the child's mind—getting used to a new environment, "What am I doing here, I feel abandoned, I feel helpless—" and so on.

Secondly it is in language which is extremely difficult for an adolescent to understand. If this is to be read to children at least let it be read in such language that is attentive to their level of comprehension.

Q. Now Dr. Feiner, if a child who is admitted to an (25) institution in the manner now under the law objected under these regulations and then after a court hearing was released back home and found not in need of hospitalization, could that have any bad or negative effects on the child?

A. Yes, clearly if the parents have gone to this length, they will be resentful. They are likely to take it out on the child, who is the most immediately available scapegoat. The child will feel resentful. There has been no communication established between them, and it is likely to have a very destructive effect. I would also say that none of the other possibilities or alternatives are elaborated in this statement, so the child may simply say "I want to remain here, because this is known, I am already here," and the other alternative is "I don't know, I'm going to take the safest place for now, because I am already here."

Q. So that would be a reason that children who really do object wouldn't want to say so?

A. Yes, it would be.

Q. Now, the negative effects of getting to the hospital and then leaving after a hearing which results in a finding in favor of the child, is it your opinion that that

would be a reason to have the hearing prior to the commitment?

A. I think that there is good reason for having it prior, (26) so that other alternatives can be looked upon without having any more steps interposed.

Q. Dr. Feiner, for children under 13, do you feel there is any need or reason to have an Advocate or some procedure to examine the institutionalization of those children?

A. Well, we often do have Advocates for children under 13. Bureau of Child Welfare is an Advocate in our city for children under 13.

Q. You mean in other contexts?

A. In other contexts, right, and I think that contexts can be extended. As I said, there may be the perception or the experience, rather of feeling hopeless and helpless in this situation if the child's needs are not being met.

I would also say about school age kids, and adolescents, that there is particular attention that they pay to issues of fairness, that fairness and what is just is a very important issue in the development of children—of school age and of adolescents, and we often see children being able to repeat rules and to have clubs with very elaborate guide lines to follow so that they are very sensitive to issues of fairness, and it has been said that some children would rather be fair than be loved. So, there is a sense that a judicial hearing responds to in children.

(27) Q. Dr. Feiner, with reference to the need or the desirability for having judicial commitment hearing for mental hospitalization, could you tell us whether you think there is any special difference in the psychological make-up of adults, vis-a-vis children which would mean that it

is appropriate for adults to have hearings but for children not to have hearings?

A. Well, I would see some differences, but I could see them even in answering the reasons for children to have hearings—I mean adolescence is a period of life where—in which the person experiences the feeling of being an outsider. One can see this in the kinds of identifications that adolescence makes of minority groups or outlaws, all kinds of outsiders, so the adolescent often has the outsiders view of injustice, of being alone, of being isolated, of needing some kind of contact and so forth, and if it is not readily forthcoming from one's immediate environment, which it often is not, then one needs it from someone else, and the presence of a lawyer or at least a court hearing, as that possibility can be reassuring.

MR. FERLEGER: You may cross-examine.

Cross-Examination

BY MR. ROTH:

Q. Dr. Feiner, now it is my understanding that you became a psychiatrist in 1970; is that correct?

(28) A. No. I finished my adult psychiatric training in 1968.

Q. And you finished your residency in '68?

A. '67 and '68, right. I combined the third year of my residency with the first year of my Child Psychiatry sub-specialty training.

Q. Have you offered any articles in the field of Child Psychiatry?

A. I have given professional papers, but I currently have not offered articles.

If I may say so, I have been working providing a service for 12 hours a day over the past—at least 5 years.

Q. But you haven't offered any articles; is that correct?

A. That's correct.

Q. Doctor, now when you finished in—did you complete this course of Child Psychiatry in 1970, then?

A. That's correct. I took an extra year of Child Psychiatry so I could work half-time for 2 years in a hospital in a ghetto area of New York City.

Q. When you completed in 1970, did you become affiliated at that time with Lincoln Hospital?

A. That's correct.

Q. What was your role at the Lincoln Hospital?

A. At that time I was the only Child Psychiatrist on the (29) staff, and was responsible for service and supervision of children on an outpatient basis.

Q. Now, is Lincoln Hospital a private hospital?

A. No, Lincoln Hospital is a New York City hospital.

Q. You were responsible for children on an outpatient basis; is that correct?

A. That's correct. Children and adolescents.

Q. But the hospital, I assume also maintained institutionalization on an inpatient basis; is that correct?

A. There were institutional facilities available, but not in the hospital itself. The hospital is located in a very poor area and needs to go elsewhere for its inpatient beds.

It is a sad fact of life.

Q. How would a patient come to you at Lincoln Hospital?

A. The patient would—

Q. In terms of—

A. You mean child?

Q. Child, yes.

A. Most of the time the patients were sent by the schools. Over 90 percent of the children were referred from the schools. Occasionally they would be referred from other agencies or from pediatric departments, and very occasionally would they be self-referred.

(30) Q. And these children are from a ghetto area, I take it?

A. That's correct.

Q. Are you still associated with Lincoln Hospital?

A. I am currently associated with the Lincoln Community Mental Health Center, which is a different facility.

Q. And what is your role at the Lincoln Community Mental Health Center?

A. I am the Director of a Satellite Clinic, and responsible as well for all the child psychiatry that goes on there.

Q. And in terms of your role, how does a patient come to you at that Mental Health Clinic, a child?

A. Exactly the same way, only in this case I have developed programs which have more outreach possibility—potential.

Q. Do you ever have a situation occurring where your evaluation of a juvenile requires institutionalization?

A. Very occasionally, we do.

Q. And what is the process, then?

A. The process is first to work in terms of the child of an approach that I described earlier, that we have on our staff a number of people who are from the community. We are located right in the community. It is extremely easy, and important to us that we go to the source of the complaint—if it is the school, we may go there or request

that the (31) school personnel come to our clinic. If it is the family, we will likely make a home visit. We will extend ourselves in every way possible under the constraints of time and personnel that we have there to try to resolve the problem in ways that will avoid hospitalization.

Q. Now, assuming you have explored all those other alternatives, what occurs then, where it has not been successful to utilize another avenue for treatment?

A. Occasionally there will be need for hospitalization. I am not denying it.

Q. And then what happens, who admits the juvenile in New York?

A. There is an admitting hospital, which is another City hospital, and there are—actually there are a couple of ways that this can be accomplished. There are occasional needs for emergency hospitalization.

Q. I am not talking about emergency hospitalization.

MR. FERLEGER: Mr. Roth, can you let him finish his answer before you interrupt?

MR. ROTH: Well, I will rephrase the question, Doctor, so we won't have to go on avenues that we don't know because of time.

BY MR. ROTH:

(32) Q. With regard to non-emergency—

A. With regard to non-emergencies, we usually have a variety of treatment facilities available to us. We then participate with the family and the child in investigating those facilities. We make a visit with them. We talk to the people there, and we go through a procedure in which the family and the child have the opportunity to freely discuss their opinions of this particular place. We have some

residential treatment centers. We have a children's hospital, which is part of the state system, but what we do is we participate with the family and the child in this procedure.

Q. In terms of admitting a juvenile to an institution, who can do it in New York?

A. In terms of admitting, on an emergency basis?

Q. On a non-emergency basis?

A. On a non-emergency basis, a community physician can do it, I believe and the psychiatrist in the receiving hospital.

Q. Isn't it a fact true, then, under New York law only the parent, legal guardian or next of kin or the application of the director of the institute can admit the juvenile?

MR. FERLEGER: I believe that New York statutes on which the court can take judicial notice would answer that question. I don't think that Dr. Feiner is (33) qualified to speak authoritatively on what the New York statutes say. I think the statutes speak for themselves.

THE WITNESS: What I would like to say—

BY MR. ROTH:

Q. Doctor, with regard to that question now, you have already testified as to admitting procedures, and I am questioning your familiarity with New York law on these procedures.

Now, is that not in fact the case on how a juvenile can be admitted?

A. I believe that it is.

Q. What is the distinction?

MR. FERLEGER: Excuse me, have you finished your answer, Dr. Feiner?

THE WITNESS: Well, I want to suggest operationally that we proceed very much as the child and parent advocates. We consider ourselves to have an ongoing relationship with them, in pursuit of a proper treatment for the situation, and we will have exhausted other community based possibilities before we pursue any kind of hospitalization.

BY MR. ROTH:

Q. Now, in terms of juveniles and their admission process in New York, is it similar to the laws of Pennsylvania?

(34) A. For 16 to 18, the patient has been given notice in writing to the director that they desire to leave.

Q. What about the admission of?

A. An admission, under 16, they can be received as voluntary, on the application of the parents, guardian or next of kin?

Q. And after 16?

A. After 16 the director of the hospital may use his discretion in deciding whether to admit or not.

Q. With regard to release?

A. With regard to release, my understanding is that the patient gives notice in writing to the director of their desire to leave. They must be relieved unless they are—it is an involuntary commitment, at that point they can apply—the hospital can apply for a court order within 72 hours, the date for the hearing must be given no later than 3 days from the time the court order is received and the patient, if the decision is made to commit them, the patient is committed for a period not exceeding 60 days.

Q. Doctor, now with regard to that, is it your understanding of the New York law that if a patient is under 16 years of age that patient may notify the director of his release?

A. That is my understanding.

(35) Q. And the patient—is it finally your understanding that the patient can be detained at the institution for 72 hours during which time a county court or the Supreme Court should be notified? Is that correct?

MR. FERLEGER: I have to object, again to this whole line of questioning in Mr. Roth's attempt to get the New York statutes into the record through the words of somebody who is not a lawyer, who is not familiar with the case law in New York; not familiar with amendments which may have been enacted now or a year ago or 2 years ago under the New York statute. I see Mr. Roth has a copy of the New York statute, and I am sure if he wants to introduce that as an exhibit to save Dr. Feiner's time and to acknowledge the fact that he is not an expert in the law, I wouldn't object to the New York statute being introduced as an exhibit. I don't see any necessity for Dr. Feiner to contend to be an expert in the law. He is a Child Psychiatrist, not a lawyer.

BY MR. ROTH:

Q. Dr. Feiner, with regard to the questioning that I have been imposing, in terms of the release provisions, now, you have already testified that you are somewhat familiar with the admission and release procedures, I would assume, in New York with regard to the release provision. Is it your understanding (36) that a patient can be detained 72 hours?

A. That is my understanding.

Q. And thereafter, according to court order, could be detained as long as how many days?

A. No longer than 3 days from the time the court receives the notice.

Q. And then when does the hearing occur, do you know?

MR. FERLEGER: The record will show that Dr. Feiner raised his hands in a shrug of speculation.

MR. ROTH: I think Dr. Feiner is capable of answering, either yes or no or explain it.

THE WITNESS: I am not sure of the answer to that question.

BY MR. ROTH:

Q. Have you ever been involved in any of these proceedings?

A. With the court? No, I haven't.

Q. With regard to—I notice in answering some of our questions on the admission and release procedures you were reading from something. Could you explain what you were reading from?

A. I happen to take down some notes from Section 3113 of the New York State statute.

Q. Dr. Feiner, are you aware of any judicial proceeding in (37) New York prior to the admission of a juvenile by his parent under 16 years of age?

MR. FERLEGER: That is totally irrelevant to this case whether or not Dr. Feiner agrees with or disagrees with New York law. He, of course like all of us obeys the law in New York and doesn't make his own laws, and whether or not there is a judicial

proceeding in New York doesn't matter in terms of his testimony, just as his testimony isn't affected by the fact that in Tennessee similar laws are ruled unconstitutional.

BY MR. ROTH:

Q. Not withstanding the testimony by opposing counsel, his objection is noted, would you answer that question?

A. I would simply say that I follow the law as I understand it when the situation arises. I—if you are asking me my opinion of the law—

Q. I am not. I am asking you if there are any judicial proceedings afforded a juvenile prior to admission by a parent in New York.

MR. FERLEGER: The law speaks for itself.

THE WITNESS: I would agree.

MR. ROTH: I would appreciate, Mr. Ferleger, if you would allow your client and your witness to answer or if (38) you would object accordingly.

THE WITNESS: I have availed myself of immediate access to legal advice as a condition of my work. I have a number of lawyers who are quite familiar with this law, immediately available to me for advice when these matters arise.

BY MR. ROTH:

Q. Doctor, now you testified, and I will come back to the admission procedure, but with regard to some other things, you testified that the children's behavior, in many instances is a result of the environment in which he is located. Now, is it your testimony that many juveniles are

the scapegoats of familial problems, and as a result find themselves in institutions?

A. Yes, I will.

Q. And how do you arrive at that opinion?

A. I arrived at that opinion by making an evaluation of a family situation, which I think has as much or if not more legitimacy as any valuation of any individual child. We simply do it by an evaluation of a family, of a family setting with the child often in his family, and we do the interview on occasion with the entire family.

Q. Well, how many juveniles have you seen institutionalized (39) in New York incorrectly as a result of family problems?

A. Many. I would indicate at the same time that the diagnostic interview is not only a diagnostic interview, the interview is an attempt to defuse a potentially explosive situation. This family has come in crisis. We do not set ourselves apart, and do a detached kind of interview. We are very active, and very much desirous of defusing this situation and orienting ourselves to this family's problem.

Q. Okay. You practiced, I recall in a ghetto area; is that correct?

A. That is where I—that is where my clinic is, that's correct.

Q. Do you find that most of the people in that area avail themselves of either the law or medicine when they need it?

A. I don't know what that means.

Q. I mean do they make use of contacting their neighborhood legal service attorney or their community oriented physician or are they afraid to, in many instances?

MR. FERLEGER: That question is so vague. Of course sometimes people do. Sometimes people don't.

MR. ROTH: Mr. Ferleger, if you want to object, I don't like the idea of your testifying on behalf of the (40) doctor.

THE WITNESS: Obviously sometimes people do, because all of us that work there in any service capacity are overwhelmed, and whether we reach as many people as need our services, I can't tell you and I seriously doubt it.

BY MR. ROTH:

Q. Do you find that because—obviously I would think you would have some understanding of the environment in which you work that either people are hesitant or reluctant to contact attorneys or doctors.

A. Or people are simply demoralized and overwhelmed with such a variety of problems, that it is hard to set priorities, and their experience with service agencies is so demoralizing that they seek other solutions, often desperate ones.

Q. Do you feel that by having a juvenile participate in a judicial proceeding prior to any admission, that this may cause a reluctance on the part of any parent to utilize this system in that area?

A. I think it would certainly dignify the whole system to the juvenile.

Q. I didn't ask you that, I asked you whether or not it would?

A. I would tend to think not, because my experience often is, (41) as I have mentioned, that parents very often are there at the behest of another agency, such as the

school, and they are doing it because somebody who they have been led to believe has their interest in heart has sent them to a facility, and they are going ahead with it, because they feel that the consequences of not going ahead with it are worse, and they have been led to believe that hospitalization can be a benign situation, so I would say that very often availability of legal help in these situations is a tremendous relief to everybody involved.

Q. Now, in Pennsylvania are you aware of how a juvenile may end up at an institution?

MR. FERLEGER: The question is not clear as to whether you mean whether the statutes are in the doctor's awareness.

MR. ROTH: I am asking the doctor—of course he is aware of the sections being questioned, and I am also asking practically if you had any awareness.

THE WITNESS: No practically I haven't. I haven't worked in Pennsylvania.

BY MR. ROTH:

Q. Okay. With regard to the procedural safeguards, if you will that I attached to a juvenile—

(42) MR. FERLEGER: Are you referring to the regulations?

MR. ROTH: Yes.

I believe there was a statement made earlier by your attorney—

MR. FERLEGER: I am not Dr. Feiner's attorney.

MR. ROTH: By counsel for Plaintiffs, who is using you as a witness, that there was a brief evaluation done prior to admission of juveniles in institutions.

Now, according to your reading of the regulations, do you find that necessarily—do you find any words in there that say "Brief evaluation"?

THE WITNESS: No.

BY MR. ROTH:

Q. Now, with regard to the process in Pennsylvania, there are base service units. Do you know what base service units are?

A. I do not.

Q. With regard to the procedure in Pennsylvania whereby a juvenile is—well, let me ask you this, strike that.

What is your understanding, based upon your reading of the regulations of how a juvenile would arrive at an institution?

MR. FERLEGER: I think the regulations speak (43) for themselves. If Dr. Feiner wants, he can read them, because the only thing he has to base his understanding on is a text of the regulations, so any interpretation of that would be irrelevant and superfluous.

MR. ROTH: Well, the question remains doctor, and it is essential, as you know, Mr. Ferleger that Dr. Feiner knows what is in question, and his opinion of the same, and I am asking you, based on your reading of the regulations and so forth, can you tell me what your understanding of Pennsylvania procedures are for the commitment of a juvenile?

THE WITNESS: I do not understand—it does not indicate the patient flow, if you will. I have simply been made aware that there [are] a number of juveniles who end up in a hospital still against their will regardless of what is presented.

BY MR. ROTH:

Q. And how did you arrive at that factor that juveniles are hospitalized against their will in Pennsylvania?

A. I have been apprised through the material furnished regarding this case.

Q. What specific instances are you referring to?

A. Well, I would say in general that if I am asked about—I mean if you want to ask me some specifics about some specific (44) cases, I would be happy to comment on them. I think I actually am, in testifying in regard to the involuntary hospitalization of juveniles.

MR. FERLEGER: I might note for the record that Mr. Roth has stipulated to tables and statistics which were written with his assistance and help indicating that juveniles do in fact on occasion object to commitment, and that, it seems to me, is not a disputed aspect of this case. We know that some children don't want to be in hospitals and some children do.

BY MR. ROTH:

Q. There is no dispute as to the objection. The question remains as to how you know that juveniles are incorrectly admitted to institutions in Pennsylvania?

A. I did not say incorrectly.

Q. Inappropriately?

A. I said "Against their will."

Q. Now Doctor, with regard to some of the comments you made of Dr. Max Sugar's deposition, did you ever hear of Dr. Max Sugar?

A. I believe I read something that he has written. I have seen his name.

Q. Do you know, in review of that deposition, which you (45) said you have done—

A. I said that I did not do an entire review of it.

Q. What parts of it did you review?

A. I read about half. I read his depostion and you were questioning of him.

Q. Pardon me?

A. I read his statement with your questioning. I did not get beyond that.

MR. FERLEGER: You are referring to the direct examination of Dr. Sugar by Mr. Roth?

THE WITNESS: That's correct.

MR. FERLEGER: You read that?

THE WITNESS: That's right.

BY MR. ROTH:

Q. Do you recall Dr. Sugar testifying as to the problems that would occur if a judicial hearing were afforded prior to admission?

A. Yes. I recall that.

Q. With regard especially to the delay in treatment?

A. Yes.

Q. Do you feel that is an incorrect response?

A. Because—yes, I do, because as far as I am concerned, treatment begins the very first time that the patient, and/or (46) family steps foot in any mental health facility; that, to me is when treatment starts, not at some point at which somebody enters the ultimate door.

Q. But again, Doctor, taking into account, if you will the procedures in Pennsylvania whereby children are just not placed on doorsteps of institutions, but have been subpoenaed and evaluated by several psychiatrists prior to the ultimate detention of them—

A. Yes.

Q. Don't you feel that there has been adequate safeguards provided at that point?

A. No, because I question the evaluation, and as to whether it takes into account the entire context of the child's life.

According to Dr. Sugar, he would evaluate the child and he does not seem in the testimony to be entirely responsive to the kinds of communications that go on in the family, and he seems to assume in his testimony that parents exist all the time for the good will and the best interests of their children. I question that seriously.

Q. Now Doctor, you did not read the cross-examination, I take it of Dr. Sugar's cross-examination?

A. No.

Q. In which questions were asked by Mr. Ferleger, regarding (47) the whole familial situation?

A. Yes.

Q. So then I guess it would be difficult to ask you questions with regard to Dr. Sugar's responses?

A. I think so.

Q. Since he did take into account the entire family situation at that point?

A. My only response to that would be that it can't be a primary importance to him if he did not mention that on initial or direct examination.

Q. Well, there are some things in regard to it on direct, but let me ask you, as a professional, do most psy-

chiatrists just evaluate a child, a juvenile without evaluating the familial situation?

A. There are different ways of evaluating the familial situation, very often it will be done discreetly—that is one person will evaluate the child, one person will evaluate the parent, another person will interview the other parent. This is a traditional way that is often done in child guidance clinics.

What I am suggesting is myself and many other people see everyone together in the family, whereby different kinds of information are forthcoming.

(48) Q. Are you saying, then, that it is not customary for a psychiatrist to evaluate the entire situation from whence a patient comes, a prospective patient?

MR. FERLEGER: That has already been answered.

MR. ROTH: I am asking you that question.

THE WITNESS: That it is customary to evaluate the entire situation to develop supportive evidence for the disturbance of this child? It often is done to get history of this child, which the child himself cannot furnish, but very often it is done in order to get an understanding of a parent's own life and a parent current situation.

I can give you some examples.

BY MR. ROTH:

Q. Well, that is all right.

MR. FERLEGER: He is concluding his answer to your question.

THE WITNESS: Let me give you one example.

A child that I saw ran away—brought in to see me when he was found some miles away from where he lived. This was an 8 year old child and taking the history of the family situation, it was discovered that this child was in fact not the child of this father, but the child of another father who ran away from the family. This was a secret which the family (49) had a tacit understanding of keeping. Nobody was allowed to talk about it, but everybody knew it, including the child, because he was 3 years old and other relatives had supported his sense of what was going on. The fact that the family couldn't talk about it meant the child had to act it out, which he did and this was his way of dealing with an issue that was not allowed to be talked about in the family, but had to be acted out in terms of this child being like his original father, trying to find his original father and so on. As soon as this issue was opened up and discussed openly, the running away ceased.

There is an example of a child whose behavior was induced by the collusion of his current parents.

BY MR. ROTH:

Q. Are you saying that is a normal, that generally parents and psychiatrists act in collusion or conspiracy to institutionalize an individual?

A. No, not at all. I am saying that very often for their own needs and their own anxieties and the complicated aspects of their own nature, parents may in fact be unable to talk about certain aspects of their lives openly, and I would say that it is not always recognized that these situations occur, and even if it is recognized, I am saying it is not always dealt (50) with—you see that is the other

part of this, you see even if the psychiatrist does do an evaluation of the situation, it still does not lead to the implementation of a treatment plan that includes the entire family or that includes a psychiatrist orientation, in part because many facilities are just not tooled up to do crisis work, and they only have one alternative, which is to hospitalize.

I am suggesting that it is important that clinics and emergency rooms and other facilities be tooled up to intervene immediately so that whatever facts they do discover can be included in an appropriate treatment plan.

Q. Well, you said that when any great alteration occurs and you felt that psychiatry should not be able to make the determination, that they should submit their evaluation. Would that also occur for any other treatment plan other than institutionalization, in your mind?

MR. FERLEGER: I object to that question. I believe he has already testified that institutionalization is a much different, more serious process than other kinds of treatment.

THE WITNESS: I will consider Mr. Ferleger's objection to be consistent with my belief.

BY MR. ROTH:

(51) Q. Now, you stated that Dr. Sugar talks about the traditional point of view and that your point of view is more innovative; is that correct—or better?

A. I'd say that.

Q. Based on your experience, I mean?

A. I'd say that my point of view offers more alternatives.

Q. Is your point of view better, based on your three years of experience?

A. Does it help me for people? Does it work for me? Does it work for others that have used it? Does the literature say that it works? I'd have to answer yes.

Q. Well, where do you arrive at this new innovation?

MR. FERLEGER: Excuse me, that is a total misstatement of his testimony.

THE WITNESS: Absolutely. I have no—I'm sorry—

MR. FERLEGER: He stated on the report that this is a development in the total field of child psychiatry over the past ten years. Dr. Feiner didn't think it up, it was taught to him and every other person who studied child psychiatry in the past ten years. It is Dr. Sugar who is behind the times. We are not talking about innovations, we are talking about regular practice established—accepted (52) practice.

BY MR. ROTH:

Q. Well Doctor, let me ask you this:

If this is established practice, why is the first state or one of the few states whose statutes and laws are becoming attacked as unconstitutional, why aren't other states utilizing judicial procedures prior to admission of juveniles by parents, if this is so recent or if it has been going on for ten years?

A. What I am suggesting is that what is going on for ten years is a treatment motility that I am suggesting be applied for more situations than it currently is. It is likely that it is being applied in many places in Pennsylvania. I simply am reflecting to you the current state of the art as I know it, from what I read and the meetings that I attend and the colleagues I consult.

Q. Let me ask you this, in terms of what goes on in Pennsylvania and for example if I had a child and were having that child admitted to an institution, as the ultimate, if you will and so I went through—let's take it, if I were from a poor socio-economic background, could not afford a private psychiatrist at the outset to evaluate my child, et cetera, et cetera, including home life or anything which you might think was relevant which goes on in Pennsylvania and I went to this (53) base service unit where I evaluated my child, made recommendations they went through their entire process, okay, and then there was a recommendation that the best alternative, after making other recommendations of other outpatients through the county mental health mental retardation unit, of which there are numerous ones throughout the state, if they found in the best interest of the child that institutionalization would be a paramount and then I went to the institution and the director, then, according to the laws as you have read them in Pennsylvania has another independent psychiatric examination made to make certain that the child does not need institutionalization and that occurs and the child is detained in the institution receiving treatment, knowing full well that according to the safeguards that he objects at any time within 48 hours thereafter he is going to be afforded counsel and go through a hearing, do you find that to be inappropriate?

A. You say so much that, first of all I question the child is already receiving treatment. I think a child strongly believes that he is not—that he does not feel that it is necessary for him to be in an institution is not likely to acquiesce to the kinds of appropriate treatment within the first 48 hours, so I can certainly question that aspect of your assumption.

(54) Q. Well, Doctor let me clarify something, so you don't misunderstand this.

It is not necessarily within the first 48 hours, it is within 48 hours whenever he makes the objection, if he makes the objection at admission or subsequent thereto—we are talking about within 48 hours after that objection counsel will be afforded him?

A. Yes. I simply am saying I do not see why it can't be done before hand. After all, you have talked about an elaborate procedure that goes from one place to another to interpose this procedure before the child is admitted seems that it will afford more alternatives in case the child's position is upheld. It will decrease the amount of alienation, and those 48 hours are more in which the child has to stew and will afford the opportunity for a reconciliation if that is going to be the fact—I mean after all, if we say that there is going to be a judicial hearing and we recognize the fact that the child in fact may be upheld in his request, it is not inevitable that they are going to agree—I would assume that all of the recommendations are to be adhered to.

Q. But doctor, that assumes that when a juvenile is evaluated through the base service unit and implementation of (55) any programs as to occur, it doesn't occur until after institutionalization and that isn't necessarily so?

A. I don't understand that.

Q. In other words when a person is being evaluated, either in New York—I'm sure through your county health mental retardation units or in Pennsylvania, I would assume that psychiatrists, when they see that the problem exists are going to establish procedures to help the juvenile—they are not just going to sit by and not help them?

A. Yes, I think that is probably true, but I think we can't presuppose that amount of good will all of the time when we are dealing with somebody's rights, and I would assume that during this time the psychiatrist would be attempting to establish a rapport with this client, to perhaps do some persuasion to feed back observations, to make recommendations, and so on and even if that isn't—and if that isn't taken up by the child, I think the child should still have resource to other avenues before he is hospitalized.

Q. Well, what about the fact that when the child is hospitalized, that treatment begins when he becomes hospitalized?

A. What treatment are you talking about?

MR. FERLEGER: Objection.

MR. ROTH: I am talking about the fact that (56) recommendation and treatment plans that have been initiated prior to his institutionalization have occurred and the treatment program continues.

MR. FERLEGER: Objection, that question must be objected to on the basis of Mr. Roth is testifying about some treatment plans that are established for some unknown patients. That is not part of the record in this case.

If Mr. Roth wants to ask the doctor about his experience as director of his mental health center, then he can testify about whether or treatment takes place there, but you certainly can't testify and Mr. Roth can't testify about some alleged treatment in Pennsylvania.

BY MR. ROTH:

Q. Now Doctor, you have testified that rather than having someone stew for 48 hours—and I am merely advising you that that is not necessarily the case, and I am saying if in fact a person does receive treatment, continuous treatment, aren't those needs of the person met?

A. Mr. Roth, I'd like to correct a misconception I think you are implying, that is a person does not receive treatment, a treatment is a collaborative effort, and a person does not have treatment poured into him. Psychiatric treatment is a long arduous affair which involves the development of a (57) relationship of trust, and it cannot be done in a coercive way, so when you say "treatment," I question what in fact you mean.

Q. Well, when I say "treatment," of course not being a psychiatrist I am saying that some plan has been established by a psychiatrist that of evaluating the juvenile prior to as well as at admission, and that that plan, whatever it be is continuing, and I am saying assuming that were to occur, how—why do you feel, then that a hearing subsequent thereto, if necessary could not be held?

A. Because I question the possibility of treatment occurring under those circumstances, and I question the possibility that we are not, by enforcing this coercive situation, ruling out this patient for any subsequent treatment, at any opportunity in the future to voluntarily seek help from a mental health facility. My feeling is that this experience is more likely than not to be a negative one.

Q. Doctor, are you ever aware of situations where, because of reliance upon a judicial system, whether it be for an emergency hearing—no, I am sorry, whether it be for an emergency or non-emergency that the judicial process has been slowed to the extent that the person has com-

mitted suicide because they weren't able to get into the institution right (58) away?

A. Well, I—

MR. FERLEGER: I don't see how that is relevant. That procedure is for children. When we have judicial proceedings in Pennsylvania for adults, and if Mr. Roth is suggesting that adults be treated as children in Pennsylvania, that question is irrelevant.

MR. ROTH: Notwithstanding Mr. Ferleger's gratuitous remarks—

THE WITNESS: I would like to add, if you are hypothesizing an emergency situation, that isn't the statute under question.

MR. ROTH: I am not asking you about this statute under question, I am asking you in your professional opinion, or in your knowledge, have you ever heard of situations where a person perhaps died with their rights on?

MR. FERLEGER: Could you lower your voice, Mr. Roth? You are yelling.

MR. ROTH: Mr. Ferleger, I am sorry, I am not yelling and I am sorry you are so sensitive that you can't listen.

THE WITNESS: I am amazed that that—at your hypotheses, but I won't question that, but I have not (59) heard of such a case, quite frankly.

MR. FERLEGER: Mr. Roth—

MR. ROTH: Mr. Ferleger, I would like to continue with the examination.

MR. FERLEGER: Your questions are becoming a bit redundant and far afield from the case. Dr. Feiner has to leave in about two minutes in order to make a train, and if you have any relevant questions to ask, I wish you'd ask them now so that the deposition can be concluded.

MR. ROTH: Mr. Ferleger, with all due respect, I have many more questions to ask of Dr. Feiner.

With regard to that, the Notice of Deposition says "Is expected to be completed within two hours." Subsequent to that time, we had correspondence with our own staff indicating that we may need additional time, and there was no objection to that.

MR. FERLEGER: If we need additional time for relevant questions, I have no problem with that.

MR. ROTH: Well, I think the Court can very well determine what questions are relevant and irrelevant.

MR. FERLEGER: You are asking irrelevant questions. They don't seem to me to be appropriated if we can't conclude by the time that Dr. Feiner has to make his (60) train, then we will be glad to continue it to another day.

MR. ROTH: Well, I have numerous questions for you, Dr. Feiner.

BY MR. ROTH:

Q. Dr. Feiner, do you feel that there are differences between juveniles and adults in terms of their self-awareness regarding use of institutions, of they needed to?

A. No.

Q. In other words you read Dr. Sugar's deposition and he felt that youngsters have a lot of hormonal changes, secondary changes, growth changes—he felt that these do not become complete at the late adolescent years, and he felt that there was very much a distinction between adults and juveniles in terms of development?

A. Well, you didn't ask me that question. Of course there are. You asked me regarding the use of institutions, and I suggested—

Q. In regards to their awareness, I am sorry?

A. In regards to their awareness, I think they are individualized, and I wouldn't be prepared to make a generalization. I have seen numerous adults who were not prepared to take advantage of the institutions available to them in this society.

(61) Q. Well, one of the thrusts of this lawsuit is to have sections under the act declared unconstitutional which treat juveniles differently from adults. Is that your understanding?

A. Yes.

Q. And there is a possibility that if that were so done, that juveniles would be afforded the same rights as adults to admit and release themselves?

A. That's correct.

Q. Now, do you feel a child aged 5 would have any capacity at all to even make that determination whereas an adult aged 19—where are the differences?

A. Obviously there are significant differences, but if—I can foresee a child with an Advocate participating in a situation in which the child is realized into another situation or home.

Q. Do you think it is feasible that that occur, if—you know—for juveniles to admit and release themselves as adults do in Pennsylvania?

A. Do I think it is feasible?

Q. In your professional opinion?

A. I would not be here if I did not think it was feasible.

Q. How would a 3 year old even approach that?

MR. FERLEGER: Mr. Roth, your questions—(62) and I am waiting for you to ask about the 3½ and 4½ and the 4 and ¾ year old—your questions are just prolonging this deposition in a ridiculous manner. Obviously—and your own Dr. Sugar testified that 13, 14, 15, 16 and 17 year old kids could go in and out of institutions. We are not talking about—

MR. ROTH: Do you have an objection?

MR. FERLEGER: For younger children—

MR. ROTH: Are you testifying or do you want to object?

MR. FERLEGER: This is my objection, Mr. Roth, for younger children as the doctor testified, an Advocate is the one who would be speaking to the court, not the 3 year old and for a 17 year old severely retarded person it would be an Advocate or a guardian ad litem. Your questions are just absurd.

BY MR. ROTH:

Q. The question still remains, Doctor, in terms of the procedures which plaintiffs seek.

A. I cannot foresee that possibility of the child speaking for himself, but should the possibility ever come up, I would think that those rights would extend—I mean

—it is certainly unlikely, if not impossible that that would occur (63) with a 3 or 5 year old, but where are you going to draw the line? There are certainly some sophisticated 9 and 10 year olds, just as there are some very naive 30 and 40 year olds.

Q. Well, do juveniles who need hospitalization necessarily recognize it?

A. I think that juveniles need hospitalization on occasion, and often do recognize it. I think that adults who need hospitalization often do not recognize it, also.

Q. I am asking about juveniles. Do you have juveniles that tend to avoid reflection and introspection?

A. Juveniles may make their needs known through behavior.

Q. Let me ask you this.

Is it your testimony in part that you feel parents really do not operate in context of this situation for the well-being of their children?

A. No.

Q. Do you feel by and large parents do?

A. I think it is a very mixed bag. I am suggesting where there are enough indications where they don't require some protection, and I hope to work in a situation where we see numerous cases of child abuse and neglect—I am quite sensitized to that possibility. We are not talking about one case.

(64) Q. Have you ever admitted a child to an institution?

A. Yes, I have.

Q. To which institution?

A. I have admitted a child to Bronx Municipal Hospital Center.

Q. Were you the admitting physician?

A. Yes.

Q. And how did that occur?

A. That occurred by my following the procedures that were available to me at that time and operating under the guide lines which the institution functioned. I have since been able to participate in changing that situation to make it more flexible, and to decrease the possibility of a child being admitted under those circumstances.

Q. Do you admit many children to institutions?

A. No. I have not admitted a child to an institution personally in some time.

Q. Are you opposed to institutions?

A. Absolutely not. Absolutely not. I am not talking against admitting children to institutions, I think they serve useful functions, serve a useful function when used appropriately. I will mention another alternative which is being used as well, and that is day treatment centers where children spend their days in a community setting living at home.

(65) Just to add another alternative to the family of psychiatrists.

Q. When a juvenile comes to your facility, how long a process occurs in terms of making a recommendation of whether or not the juvenile needs an alternative type of care?

A. What procedure usually occurs?

MR. FERLEGER: That has already been testified to, Mr. Roth.

THE WITNESS: It has been testified to.

We will gather as much information as we can, and as many contexts as we can involving as many people who can provide information and opinions.

BY MR. ROTH:

Q. In the clinic where you work, how many psychiatrists are there and how many patients come in daily?

MR. FERLEGER: Objection, Mr. Roth. Dr. Feiner has to leave in—as a matter of fact right now for a train. If you have relevant questions, I wish you'd ask them quickly so we can conclude the deposition today rather than continuing it. If you want to submit Interrogatories, if you have any relevant questions left, that is fine, but the number of patients at his institution is irrelevant.

BY MR. ROTH:

(66) Q. How many patients come into your facility daily?

A. Maybe 50. I—you know, I really have to leave. I have an important and professional commitment in New York.

Q. Dr. Feiner, I have still several questions.

Do you often testify?

A. No, not often at all.

Q. How many times have you testified in the past year?

A. None.

Q. In the past 3 years?

A. Once or twice.

Q. Are you being compensated for your testimony?

A. No, I am not.

Q. In your opinion, if a methodology of treatment occurred once the juvenile was seen by whomever in terms of psychiatric evaluation, if a treatment plan were established at that point, and if there were any alteration of that treatment plan in terms of either having the patient be seen at a facility many times a week or having the patient institutionalized or anything of that sort, do you think at that point a judicial hearing should occur?

A. I think a judicial hearing should be available to a person at any time they chose to request it, and I think that it is the mental health person's legitimate responsibility (67) to explore that request, but when—I don't think he can do more than explore it, and under its meaning and the reason for it occurring at that particular point.

Q. What would happen if—if you started a treatment program for a juvenile and the juvenile objected to that treatment program, do you think a hearing should be afforded at that time and that the treatment program should stop?

A. No. I think the juvenile would—I would try to persuade, I'd try to prescribe, and if the juvenile then chose not to participate in treatment, despite all of the technical maneuvers available to me, I would not be able to treat that person, nor would I want to coerce them into treatment, because I would think that I would lose them for the possibility of treatment forever.

There are often occasions where juveniles will want a taste treatment, a little bit to see what it is like when they are brought there—they want to see who is this doctor, what is it all about, and then they will leave, because they want to come in on their own, and I have seen this happen a number of times where a juvenile has terminated treatment orally; they have said "Fine." They have gone out, they have done what they have had to do and they have come back on their own and treatment has really begun at that point.

(68) Q. But the question still remains, you feel if a juvenile objects to any point and wants a judicial hearing, that a judicial hearing should occur; is that correct?

A. Are you talking about a juvenile in a hospital?

Q. No, I am talking about when you establish a plan, if the juvenile doesn't want to participate in the plan—

A. Oh, if I am an outpatient therapist for this juvenile, I regard that completely as a voluntary contract. We use the term "contract" not in your terms, but we have established very early an understanding between us that this is completely voluntary; that it is completely confidential and at any time either one of us feels that things aren't working out and I reserve that right myself, to say that this is a situation that I don't think I can deal with, I reserve—we each reserve the right to terminate that relationship.

Q. But with regard to the question itself, if, in the best interests, in your professional opinion as a psychiatrist you feel that the juvenile should be treated, either on an outpatient basis or any other basis and the juvenile objects at that time, you feel that a hearing should be afforded the juvenile?

MR. FERLEGER: He testified—

MR. ROTH: He didn't answer the question.

(69) MR. FERLEGER: —that that implies the institutionalization, not outpatient treatment.

THE WITNESS: I have never heard of a situation—

MR. ROTH: I am not asking you what you have heard, I am asking you your professional opinion, Doctor.

MR. FERLEGER: Well, an opinion about something that doesn't happen is sort of useless.

THE WITNESS: I would have serious feelings that if a court determined the juvenile had to stay in treatment that anything useful could be accomplished under those circumstances.

BY MR. ROTH:

Q. Well, don't you feel that juveniles could be negative to admissions anywhere to institutions or day care programs but nonetheless be still co-operative in the treatment program itself?

A. Well, maybe. Maybe. Maybe a certain percentage are, but not certainly not a hundred percent.

Q. Do you find that juveniles—just by the mere chronological age are recalcitrant and as a result object to any type of methodology?

A. Oh, no, I find that recalcitrant is part of the program (70) and part of the give and take that people deal with kids have to learn to understand.

Q. Yes, but as that being part of the charm, isn't that part of the effect of objecting to anything?

A. It is not for me to coerce. I am a service employer. I am a therapist.

Q. Based on your experience, don't you find that juveniles generally object to confinement of any sort?

MR. FERLEGER: Most adults, I know object to confinement of any sort.

MR. ROTH: I am sorry, I am asking the question to Dr. Feiner.

THE WITNESS: That is the kind of idea I was trying to phrase. I think that we have due process situations, because most human beings object to confinement. If you will excuse me, I really have to go.

MR. ROTH: Well, I still have many questions.

MR. FERLEGER: How many questions?

MR. ROTH: Several.

MR. FERLEGER: Three?

MR. ROTH: Several.

MR. FERLEGER: Is several three or twenty?

MR. ROTH: It would also depend upon (71) Dr. Feiner's responses.

MR. FERLEGER: Well, at this point do you have three or twenty?

MR. ROTH: I have several.

MR. FERLEGER: Well then, we will have to conclude the deposition.

Would you like to continue the deposition to another date?

MR. ROTH: I would like to finish.

MR. FERLEGER: Or one more minute or so, if you have several we can get them done.

MR. ROTH: Mr. Ferleger, it is a shame that when you sent out the notice you said it was going to be at least two hours, and then in contact with your own staff members, if asked if we could go beyond that because we knew we would need time, we were assured of that.

MR. FERLEGER: At that point, we didn't know that Dr. Feiner had another commitment at 5:00, and we have, of course the same problem that

we had when you wanted the deposition of Dr. Sugar restricted, because he had to go give a speech and I cooperated at that point, and we finished the deposition in time for him to make the speech.

MR. ROTH: Oh, Mr. Ferleger, you showed up (72) 45 minutes late. How can you say you cooperated?

Dr. Feiner, let me ask you this, now, you have testified on direct examination that you think confinement to a general hospital is different, for example you brought up the illustration about someone who is affected with tuberculosis would be different than a mental illness, if you will. Why don't you think a hearing, prior to admission of a general hospital should occur?

THE WITNESS: As far as I know, I mean I can't be specific about the law, but I think that there are probably Jehovah's Witnesses who do avail themselves of those opportunities.

BY MR. ROTH:

Q. Well, I am asking you, though, in confinement of any person to an institution, be it a general hospital or a state institution, don't you think—you know—for a juvenile that a due process hearing should occur?

A. I am looking—

Q. Go ahead.

A. I think that there is some substantial differences between a physical illness and emotional difficulties.

Q. Don't you think parents, as you testified could misutilize a situation and put their juvenile, their child into a general (73) hospital?

A. Oh, sure, sure, and may be there should be due process.

MR. FERLEGER: Do you have further questions, Mr. Roth?

MR. ROTH: Yes.

MR. FERLEGER: Okay, the deposition will be continued to a date that I will notify you of, Mr. Roth.

Thank you, Dr. Feiner.

MR. ROTH: You can show on the record that I object to the continuation of the deposition on the basis that I was assured that I would be able to fully cross-examine the witness. I have not completed my cross-examination of the witness; that I was told the deposition would occur for at least two hours and more, and in subsequent conversation with Mr. Ferleger's staff and confirmation in writing of the same—

MR. FERLEGER: We have no problem with the deposition being finished, so that Mr. Roth will be able to finish his questions, and that is the very reason why we have continued the deposition, so that all parties can have the benefit of Dr. Feiner's testimony.

MR. ROTH: Well, I question the whole deposition in terms of Mr. Ferleger's misleading an unfair and inappropriate statements regarding the length of the deposition.

(74) (Whereupon at 3:18 the deposition was adjourned.)

File L

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

Civil Action Number 72-2272

Kevin Bartley, et al.,
Plaintiffs

v.

Haverford State Hospital, et al.,
Defendants

ORDER

AND NOW, this 21st day of August, 1974, after consideration of the parties' proposed Final Pre-Hearing Order and after a conference in chambers on July 30, 1974 regarding said order, it is hereby ORDERED:

1. Final hearing and argument herein shall take place on September 9, 1974 beginning at 10:00 A.M. in a courtroom to be designated, and on September 11 from 9:30 A.M. to 1 P.M.

2. Pre-trial briefs are not required. Any briefs which the parties may wish to submit must be filed on or before September 3, 1974.

3. The parties' Final Pre-Hearing Order, filed including their stipulation of facts and other matters, is

fully approved and adopted by the Court together with the following amendments and additions. References are to the pages and paragraphs of said order.

a. Defendants shall be permitted to call as witnesses Dr. Derek Miller of the University of Michigan and Dr. James Masterson of the Cornell Hospital in New York.

b. The "Discharge and Readmission Data" (Page 10, Par. 3) shall not be admitted.

c. The question of monetary liability of Defendants shall be briefed if and when it becomes an issue herein (Page 10, Par. 4).

d. Paragraphs 1 through 8 at pages 14 through 18 are admitted and included in the factual stipulation. Defendants shall be permitted to comment on and to make a statement on these facts. Defendants may prepare an exhibit by September 2, to be approved for accuracy and completeness by Plaintiffs, regarding the admission of the following patients' cases listed on pages 14 and 15 (noted here by institutional number):

Pennhurst #402
Polk #13,173
Polk #13,077
Western #281
Western #288
Polk #13,212
Western #144
Western #15
Western #67
Western #131

In their review of patient records for the purpose of preparing this exhibit, the parties shall protect the confidentiality of the patients' records.

e. The Plaintiffs' witnesses are as indicated at page 19 of the aforesaid order. The Defendants' witnesses are:

Dr. Derek Miller
University of Michigan
Ann Arbor 48104

Levon Tashians, M.D.
Institute of Pennsylvania Hospital
111 North 49th Street
Philadelphia, Pa. 19139

Barbarba Armstrong, M.D.
Haverford State Hospital
3500 Darby Road
Haverford, Pa. 19041

Dr. James Masterson
60 Sutton Place South
New York, N.Y.

James Gibbs, M.D.
Director of Child and Adolescent Psychiatry
Sheppard-Pratt Hospital
Baltimore, Md. 21215

Both parties agree not to contact the witnesses without approval and presence of opposing counsel.

f. Plaintiffs' Exhibits 2 and 3 may be offered at the hearing (page 21) and the Court will determine their admissibility and weight.

g. Plaintiffs may take the deposition of Dr. Joel Finer in Philadelphia, Pa. which deposition may be admitted as a trial deposition.

h. Plaintiffs shall submit three copies of Dr. Barbara Armstrong's deposition to the Court with those portions to be admitted underlined in red. All portions on which the parties disagree shall be admitted.

i. The deposition of Dr. Max Sugar may be admitted as a trial deposition.

j. The submitting parties shall give the other parties notice of the contents of their summaries as early as possible.

By the Court:

(s) Daniel H. Huyett, 3d
Daniel H. Huyett, 3d

Dated: 8/21/74

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

Civil Action No. 72-2272

[Title omitted in printing.]

EVIDENTIARY HEARING

First Day

Philadelphia, Pa., September 9, 1974
(10:00 a.m.)

Before:

Hon. John J. Gibbons, C. J.
Hon. Daniel H. Huyett, 3rd, J.
Hon. Raymond J. Broderick, J.

Present:

David Ferleger, Esq., Attorney for Plaintiffs, Mental Patient Civil Liberties Project, Philadelphia, Pa. 19107.

Barry Roth, Esq., Assistant Attorney General, Darius G. C. Moss, Esq., Assistant Attorney General, Attorneys for Defendants, Office of Legal Counsel, Department of Public Welfare, Harrisburg, Pa. 17120.

(2) (All Counsel and parties being present, the following transpired in open court.)

JUDGE GIBBONS: Mr. Roth, the first item of business I suppose is your motion to dismiss, and I should advise you we have concluded we will take that under advisement and you should proceed with the testimony.

MR. ROTH: Thank you.

MR. FERLEGER: Just for the record, your Honor, I think you have forgotten that I think that was already taken care of in a previous order.

JUDGE GIBBONS: I think it may have been, but I see it is listed.

MR. FERLEGER: I wasn't aware of that.

JUDGE HUYETT: How did we take care of it in the previous order?

MR. FERLEGER: In your April 29th order after our meeting, you asked me to draft the order which allowed the case to be maintained as a Class Action, dropped Haverford Hospital as a Defendant, appointed myself as guardian and denied the motion to dismiss.

JUDGE GIBBONS: Well, it is listed this morning. Whether that is a renewal or otherwise, we will take it under advisement.

Mr. Ferleger, do you have a witness?

(3) MR. FERLEGER: Yes, your Honor.

This morning we have three witnesses to present to the Court, all expert psychiatrists.

The first is Dr. Henry Kandler. He will testify regarding his experiences as a psychiatrist and working with lawyers.

Our other two witnesses will follow.

To save time, rather than making any statement, I'd like to call Dr. Henry Kandler to the stand.

MR. ROTH: Your Honor, if I may, I would like to make some specific requests of this Court and I'd like to do that now if that would be appropriate with regard to—

JUDGE GIBBONS: We cannot tell whether it would be, until we hear the requests.

MR. ROTH: May I be given the opportunity to present them now?

JUDGE GIBBONS: Yes.

MR. ROTH: Thank you, your Honor.

I appropriate this time, your Honor, to present several matters before your Court.

The first being through an oversight, I was under the impression that I had submitted the admission notes of Alan Moss and Donn Dickel. The opposing counsel (4) had submitted affidavits by these two youngsters who are at the Haverford State Hospital and I had spoken to Judge Huyett through his law clerk, Mr. John Langel indicating I would like to introduce into the record the admission notes of those two juveniles.

I am prepared to have Dr. Kratsa, who was the admitting psychiatrist, testify to these admission notes.

I am also prepared to have affidavits submitted by him which I have now. I sent a letter to your Honorable Court on September 3rd, indicating the admission notes of these two youngsters.

I know this has not yet been introduced into evidence by opposing counsel. However, I would like to reserve

that right to introduce these notes in order to further elucidate the position by the Defendants in this case.

JUDGE GIBBONS: Do you have any objection?

MR. FERLEGER: Yes, I do, your Honor.

These affidavits of the Plaintiffs were filed on April 25, 1973, under an order—special order protecting the confidentiality and the rights of the affiants.

Mr. Roth, not only knew about it since 1973, but never mentioned any desire to submit any (5) counter affidavits, either in the pretrial order negotiations or in our meetings with Judge Huyett. I think that once the final prehearing order has been entered that it is improper to suddenly on the day of trial or week before it, to decide that you want to submit counter affidavits.

JUDGE GIBBONS: Do you have any substantive objection?

MR FERLEGER: No. I am sure that the copies of the admission notes that Mr. Roth has are accurate copies.

JUDGE GIBBONS: You may do that and you can have them marked with the clerk and sometime before it is necessary to make reference to them.

MR. ROTH: Fine. I shall admit them now.

We will not be making reference to them in the hearing, your Honor.

JUDGE GIBBONS: We won't take the time. But I charge you with the responsibility of getting them appropriately marked in evidence before it is necessary to make reference to them.

MR. ROTH: Thank you.

I do have several other matters and again, I appreciate your indulgence.

With regard to our regulations which were (6) promulgated and adopted back in September, 1973, we had a hearing in April and I had indicated to the Court at that time how those regulations were being affectuated [sic] and in particular, I indicated a compilation of statistics compiled by Mr. Ralph Phelps of the Office of Mental Health in order to show the Court what was happening in each instance where juveniles objected to subsequent admission.

At that time it was my impression it had been introduced into the record and in order to insure that, I would prefer to introduce that also before your Honor. Again, I had alerted this situation to his Honor Judge Huyett through Mr. Langel last week and I am prepared to have Mr. Phelps come down from Harrisburg in order to testify to his compilation of these statistics.

JUDGE GIBBONS: Mr. Ferleger?

MR. FERLEGER: Your Honor, with reference to that, that was discussed as Mr. Roth indicates and I noted at that time that I had two clients who had objected to institutionalization who weren't listed on that summary so it was clear to me that factually that summary was incorrect with regard to at least two of my clients and I imagine with regard to other people across the state.

It purported to be a summary of all cases across the state in which these new regulations had been (7) involved and I don't see how, especially with non-state hospitals and I know for a fact that two cases are not listed on there, I don't see how this can be introduced into evidence at

all and I really don't see the relevance of it to this Court's proceedings.

MR. ROTH: Your Honors, if I may?

JUDGE GIBBONS: I think he would be entitled to cross-examine. The summary could go in if you had a witness here that he could cross-examine. I don't think it could, otherwise.

MR. ROTH: With regard to Mr. Ferleger's comment, the number of objections had not been listed by individual name. It just had been listed as to the number of objections and how the institutions handled those objections at the time.

JUDGE GIBBONS: I think you had better produce the witness and lay the groundwork for the introduction of the summary, so that Mr. Ferleger can cross-examine and object.

JUDGE BRODERICK: May I suggest something?

JUDGE GIBBONS: Yes.

JUDGE BRODERICK: May I suggest if the summary is corrected there could be an agreement to it, but otherwise, as Judge Gibbons has just indicated you will have to follow that procedure.

(8) MR. ROTH: Thank you, your Honor.

With regard to the prehearing order, we did agree that the Commonwealth would supply the admission profiles, if you will, of ten patients selected by the plaintiffs. I had sent these patients' profiles on to this Honorable Court and to Mr. Ferleger sometime ago and we would like to introduce those into evidence, also.

I have not heard of any objections prior to this time from opposing Counsel with regard to those ten patients' profiles.

JUDGE GIBBONS: Mr. Ferleger?

MR. FERLEGER: I have no objection.

JUDGE GIBBONS: They will be marked in evidence and again, rather than delay the witnesses, I charge you with the responsibility of having them appropriately marked before they need to be referred to.

MR. ROTH: Thank you, your Honor.

Again, thank you for this time.

With regard to our witnesses, your Honor, we had five witnesses and we have narrowed that to four witnesses. We have excluded Dr. Armstrong.

Now, it has been my review of the situation with these witnesses that each witness will take approximately an hour to an hour and a half. Today, we are going to begin with Dr. Tashjian. On Wednesday, we anticipate (9) calling Drs. Masterson, Miller and Gibbs.

Now, with regard to the time limit on Wednesday which will be from 9:30 to 1:00 o'clock, pursuant to your Court order, it would be appreciated if we could continue this for another day—to present Dr. Gibbs.

All these gentlemen are from out of state, Michigan, New York, Baltimore. I am prepared to have Dr. Gibbs come on Wednesday if you so desire. I have alerted Judge Huyett through his law clerk, to this situation.

JUDGE GIBBONS: I think we will have to anticipate only getting through two on Wednesday. Our collec-

tive judgment is that by the time cross-examination is finished, it will be so close to one o'clock as to make it impossible to complete the third doctor and we don't think it is appropriate to have him make two trips.

Therefore, you can assume that we will continue with his testimony on a subsequent date and that closing argument will be held on that same date.

MR. ROTH: Thank you, your Honor.

JUDGE GIBBONS: Monday, October 7, 1974, we will convene at ten o'clock and complete the testimony. Any rebuttal testimony should be presented at that time and we will proceed with closing argument. If need be, (10) we will continue on the 8th of October. We will advise you of the courtroom.

MR. FERLEGER: Thank you, your Honor.

MR. ROTH: Thank you, your Honors.

Your Honors, with regard to the pretrial deposition of Dr. Max Sugar, that deposition I would like to introduce into the record, also.

Now, I have provided the Court with a rather lengthy summary of that deposition some time ago and last week, I did receive the signed copy—the signed original— of Dr. Sugar's deposition by him and I had advised him, you know, pursuant to Court Rule 30, that he ought to state in an accompanying letter any objections that he had to form and substance.

Dr. Sugar merely changed some words around on the original deposition. He has supplied me with that, but not provided me with reasons. I can assure this Honorable

Court, as well as Mr. Ferleger, that there has been no changes as to substance.

Nonetheless, I'd like to introduce that pretrial deposition, as well as the changes on xerox sheets which I have, and reserve it for Mr. Ferleger's objections.

JUDGE GIBBONS: Mr. Ferleger, any objections to that course?

(11) MR. FERLEGER: No, I haven't seen the corrections and I'd like to.

I might note, just for the record, that Dr. Finer, who was deposed by the court order in this case, I'm still waiting for the court reporter's transcript, because we did not have time for Mr. Roth to finish his questions and he has agreed to submit interrogatories and we hope that will be done by October the 7th.

MR. ROTH: That was my next point.

Hopefully, I will have that done by October 7th. In any event, I will have that certainly done before the record is closed in this case.

With regard to Dr. Armstrong's deposition which was taken, I believe, in March of 1973, your Honors, we have agreed that Mr. Ferleger would underline portions agreed upon and those portions disagreed upon would be admitted into evidence.

I have not yet received that, although I have received several papers from Mr. Ferleger just a few minutes ago and I believe one of those papers does refer to the deposition of Dr. Armstrong. I haven't had a chance to read any of these. However, I just wanted to indicate to the Court that I am agreeable to submitting the deposition of Dr. Armstrong in its entirety, if necessary.

(12) JUDGE GIBBONS: All right. Again, I charge you to have it appropriately marked. All of these depositions have to be marked in evidence.

MR. ROTH: Fine.

Your Honor, I believe Mr. Ferleger will be introducing that deposition in accordance with our agreement.

JUDGE GIBBONS: If it is your offer, you, Mr. Ferleger, are responsible to having it marked in evidence.

MR. FERLEGER: Certainly, your Honor.

MR. ROTH: With regard to my understanding of what is in the record, specifically, we are requesting that all the interrogatories and answers are in the record and especially the answers to—

JUDGE GIBBONS: Have they been marked in evidence?

JUDGE HUYETT: They have not been marked.

MR. ROTH: No, they haven't. I believe we discussed that at the prehearing conference and I believe we decided they would all be introduced into the record.

MR. FERLEGER: There was no decision to abandon marking them.

JUDGE GIBBONS: They should be marked, (13) because they are not in the record for appeal purposes, unless they have been admitted into evidence.

JUDGE HUYETT: I would suggest that Counsel get together before October 7th and give them the next exhibit numbers so they are marked and then they can be formally admitted into the record. Just because something

has been docketed and filed, does not make it part of the record for appeal purposes.

MR. ROTH: Thank you, your Honor, we shall do so.

Again, I had spoken to Judge Huyett through Mr. Langel last week, regarding the submitting the biographies of the expert witnesses and perhaps we can arrive at a stipulation with regard to that.

Neither Mr. Ferleger nor I have exchanged the Curriculum Vitaes of the witnesses and it would be my feeling at this point, your Honor, although I'd like to expedite the hearing that perhaps we should hear the qualifications and if your Honors feel we should submit the biographies, we will, but I think it is necessary to hear the qualifications.

JUDGE HUYETT: Are these fairly short?

MR. FERLEGER: Just to let you know what the plaintiffs are doing. You have, I handed up this morning before you arrived, Plaintiff's Exhibit Numbers (14) 1, 2, and 3. Number 1, the Court has already ordered, it may be admitted. Numbers 2 and 3, the Court has given us permission to submit them here this morning.

Dr. Leon Ginsburg, as I explained to Judge Huyett in a paper filed, he is in South America. The affidavit has been filed for more than a year, I believe, although Mr. Roth has told me that he did not get it when we originally sent it out.

Exhibits 4, 5, and 6, are the resumes of our expert witnesses and I would move, maybe to expedite things, for the admission of all of our Exhibits at this time.

JUDGE GIBBONS: Move the admission of each Curriculum Vitae as the witness is on the stand, so it appears in the same part of the record.

JUDGE HUYETT: Are they too long to read?

My thought is to save time and if the Curriculum Vitae is short it could be read and this would be supplemented by a few questions, rather than going through a long procedure of questions and answers.

MR. FERLEGER: What I was anticipating was having my witnesses describe the most salient points of their qualifications and leave a lot of the listings of articles and talks to the written material.

JUDGE GIBBONS: Just mark the Curriculum (15) Vitae as each witness gets on the stand and present those highlights that you think are appropriate by question.

MR. FERLEGER: I will, your Honor.

JUDGE GIBBONS: Anything else, Mr. Roth?

MR. ROTH: Yes, your Honor.

With regard to my brief which was submitted about two weeks ago, I would just like to note a correction on page 22 and it appeared that the citation of Logan versus Arafeh, that should be Volume 346, your Honor. I'm sorry for that.

Your Honor at this time, that is all I have. Thank you again.

MR. FERLEGER: Dr. Kandler.

HENRY O. KANDLER, sworn.

THE CLERK: Would you state your full name?

THE WITNESS: Dr. Henry O. Kandler.

Direct Examination

BY MR. FERLEGER:

Q. What is your address?

A. My office is 124 East 84th Street in New York City.

Q. What is your occupation?

A. I am a psychiatrist.

Q. Would you please give to the Court briefly your (16) current affiliations or appointments?

A. Yes.

I am Assistant Clinical Professor of Psychiatry at the Albert Einstein College of Medicine and I am Associate Attending Psychiatrist at the Bronx Municipal Hospital Center.

Q. Have you been associated with any hospitals in the state hospital system?

A. Yes; for a period of five years I was Supervising Psychiatrist at Bronx State Hospital.

Q. What are your current responsibilities at the Albert Einstein College of Medicine?

A. Right now I am Associate Director of Adolescent Psychiatry at both the medical school and hospital.

Q. What do you do in that capacity?

A. Primarily, I supervise trainees, fellows and residents who work in the clinic right now and I am also in charge of the school consultation program and have some administrative duties as far as the clinic is concerned.

Q. For how long have you been involved in the area of child psychiatry or adolescent psychiatry?

A. For 16 years.

This clinic job is a new one for me. For the past 16 years, I have been involved in in-patient psychiatry.

(17) Q. What facilities?

A. At the same facilities that I have mentioned.

Q. Can you estimate the number of children involved that were under your responsibility or supervision?

A. We admit somewhere between 60 and 100 adolescents a year, depending on how those services were set up.

I was usually, during this period of time, in charge of one ward. So that would be about one-third of them. So, I estimate that I have been in perhaps direct charge of 400 adolescents who have been admitted to our hospital.

Q. Do you work with children or families of children in your private practice?

A. Adolescents, yes. Not younger children.

Q. Dr. Kandler, you have seen the Curriculum Vitae that you gave me and it is now in the Court's hands.

Is that an accurate summary of your qualifications and background?

A. Yes.

MR. FERLEGER: Your Honors, I'd like to move for the admission of Plaintiff's Exhibit Number 4.

JUDGE GIBBONS: Number them in sequence as to whatever the next plaintiff's number is.

JUDGE HUYETT: Were your Exhibits 1, 2, and 3 admitted at the prehearing conference?

(18) MR. FERLEGER: Yes. Exhibits 2 and 3, your Honors ordered we'd be allowed to submit for a ruling today.

JUDGE HUYETT: Where are Exhibits 1, 2, and 3, physically? Have they been marked?

MR. FERLEGER: Exhibit 1 has already been docketed and filed. Exhibit 3 has already been docketed and filed and Exhibit 2 has been docketed and filed, as well.

MR. ROTH: If I may, your Honor, as I recall the Exhibits were disagreed upon in our statement of facts and it is up to the Court in order to determine the probative value today.

MR. FERLEGER: Except for Number 1. Number 1, Judge Huyett ordered admitted.

JUDGE HUYETT: Where is there a reference to these in the prehearing order?

MR. FERLEGER: In your order issued after our last conference, at paragraph 3(f), your Honor ordered that plaintiff's Exhibits 2 and 3 may be offered at the hearing and the Court will determine their admissibility and weight.

MR. ROTH: Exactly. In that order, it does not say anything about Exhibit 1. It was my understanding that this Exhibit was not admitted.

(19) JUDGE GIBBONS: Let's not talk about Exhibit 1 at this point. Let's get a number for what you referred to as "Exhibit 4."

The previous Exhibits have been given numbers 1, 2, and 3 in the prehearing order and this will be

marked Exhibit 4 which will be admitted in evidence.

Give the Clerk a copy for the Court to file.

(Whereupon, the Curriculum Vitae of Dr. Kandler was marked Plaintiff's Exhibit 4 in evidence as of this date.)

MR. ROTH: I do have some questions with regard to the witness' qualifications.

JUDGE GIBBONS: You may examine now on his qualifications.

MR. ROTH: Thank you, your Honor.

MR. FERLEGER: Your Honor, if Mr. Roth is just going to question with regard to the extent or stature of his qualifications, I think he should hold that for cross-examination, but if he wants to question—

JUDGE GIBBONS: He may examine on his qualifications at this point.

MR. FERLEGER: Thank you, your Honor.

MR. ROTH: Thank you.

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(20) *Cross-Examination*

BY MR. ROTH:

Q. Dr. Kandler, would you please indicate to me if you are Board certified in general psychiatry?

A. No, I am not.

Q. Are you Board certified in child psychiatry?

A. No, I am not.

Q. Are you Board eligible in general psychiatry?

A. Yes.

Q. Are you Board eligible in child psychiatry?

A. I am not sure—I think you have to have the general first.

Q. Can you please explain the difference between Board eligibility and Board certification?

A. The difference is taking an examination and passing it.

Q. Is it not true, Doctor, that Board certification indicates an acceptable level of expertise in that area of psychiatry?

A. I personally don't believe so.

Q. Does not that Board certification indicate what I just revealed to you?

A. I don't believe so, no.

MR. ROTH: Your Honor, at this time, I will reserve questions with regard to his experience (21) and history in general and child psychiatry for cross-examination.

Continued Direct Examination

BY MR. FERLEGER:

Q. Dr. Kandler, as you know, this lawsuit involves the rights of children to have pre-mental commitment judicial hearings. That involves the relationship between the law and psychiatry.

Have you had any experience with lawyers being involved in commitment proceedings and can you describe that experience?

A. Yes, rather extensively.

In New York State for several years now, we have had a mental health information service, which was set up by state law and which is an arm of the Court that is responsible for commitment proceedings and under this program, every hospital has a lawyer or there are lawyers responsible for several hospitals if the service is small, who is available to all patients—all patients, that includes children, adolescents and adults, to discuss with them their rights and to help them with any complaints they have about being in the hospital.

Q. Have you had contact as a psychiatrist with one of these lawyers for your patients?

A. Yes, extensively.

(22) Q. Do you have any opinions regarding the benefit or disadvantage to those juvenile patients of such contact with attorneys?

A. I think it is proven over the years to be an advantage. The advantages are several-fold.

First of all, it relieves the psychiatrist from wearing two hats, from both having to be responsible with seeing that a patient is apprised of his rights and explaining something that he is not an expert in while at the same time being a psychiatrist.

I think it leaves him free to make a reasonable judgment and recommendation to a patient about hospitalization and treatment without at the same time having to say, "However, if you don't agree, you can go to Court and have this reviewed."

I think at the same time it provides for better legal advice for the patient, because there is an expert who is well versed in these rights advising the patient.

Q. Do you feel that your treatment of juveniles is hindered at all by the juveniles being represented by an attorney?

A. Not at all. I find it helpful.

Q. In cases where there is a disagreement about the need for treatment, do you find that the adversarial (23) stance of the lawyer ever interferes with the best interests of the juvenile?

A. I haven't found it so. I think what happens is that it does not come to a hearing. I think the mere fact that that possibility exists leads to both from the legal point of view and from the psychiatric point of view, the best compromise solution being found to help the patient.

Q. Dr. Kandler, I wonder if you would give us your opinion regarding the reliability of parents of possibly disturbed youngsters as the source of information with regard to commitments?

In other words, do you think that parents should be relied upon to make applications for the commitment of children?

A. Well, I think some parents are reliable and some parents are less reliable.

Some parents are very angry at their children and would like to have the children placed somewhere else and some parents are honestly mistaken in their judgments.

So I think you get a whole panorama of possibilities.

Q. Do you feel that there would be any advantages from a prior judicial hearing for the commitment of a juvenile (24) in a non-emergency situation?

A. I think the advantage is an indirect one.

In a sense that when the possibility of a hearing exists, then those agencies or people that consider that it is in the best interests to have the child placed in a hospital,

have to make sure that the child or adolescent is thoroughly worked up and the case is thoroughly understood and there is an agreement it is in the best interest of the child.

The advantages, it makes a better situation beforehand, putting everybody on notice to do a better job.

Q. Are there any therapeutic aspects to the child in having a hearing or representation by Counsel or an advocate?

A. I think there are two.

First of all, I think what happens is that rather than arbitrarily railroading a child into the hospital, the situation has to be explained to the child very thoroughly and this also goes on once the child is in the hospital that the staff makes an effort to try to explain to the child why he is there and why it is necessary for him to be in the hospital and what type of treatment his is getting and I think that makes a better treatment.

(25) In psychiatry it is difficult to treat a patient without the cooperation of the patient and even at times during an emergency situation one has to admit a patient quickly against his will. Nevertheless, eventually, you need the cooperation of the patient. Even if it is only as simple as taking medication, if the patient leaves the hospital and discontinues taking the medicine it is harmful. Especially in the case of psychotherapy.

The second advantage is it gives the child a sense of trust and responsibility, because he has some other alternative. He can go for advice to someone who is an expert, who may either advise that the child cooperate in the treatment or suggest that the child have a hearing and try to get out of the hospital.

Q. I understand that in New York, as the law is in the City of New York, the hearings are on a challenge to a commitment once it's been accomplished.

Do you see any reason why your comments would not apply to the treatment situation as well?

A. In general, no. There are emergency situations in psychiatry and there must be some procedure by which one can safeguard the patient from harming himself or other people when the situation is one of immediacy.

Otherwise, I think it would apply.

(26) Q. You are generally familiar with the emergency provisions of the Pennsylvania Mental Health Law.

Do you think—

JUDGE GIBBONS: Wait a moment.

Ask him, is he, first.

Q. Dr. Kandler, are you familiar generally with the fact that Pennsylvania has emergency provisions for commitment procedures?

A. I know they do.

Q. Do you feel those procedures are generally adequate for the emergency where—

A. I don't know the details enough of the Pennsylvania law.

Q. Thank you.

Dr. Kandler, would you please explain whether or not you feel there are differences between institutional, inpatient juveniles in a psychiatric facility as opposed to outpatient care or general medical care, differences which merit a prior hearing?

A. Well, I certainly do.

I think when you lock someone up, you deprive him in large measure of control of his life and I think this ought to be done carefully.

Q. Dr. Kandler, do you know whether there are any national medical or psychiatric standards regarding the (27) provisions of legal counsel for due process to children?

A. Probably the most pertinent one is in the latest accreditation manual for psychiatric facilities serving children and adolescents.

Q. Who published that or wrote that?

A. This is published by The Joint Commission on Accreditation of Hospitals.

Q. Who are they?

A. This is an organization that was formed over 20 years by the American College of Surgeons and Physicians and The American Hospital Association and The Medical Association and Their Approval of Hospital Facilities. In this instance Psychiatric facilities for children very often determines whether they get funds and is certainly involved in their getting federal funds and let me quote, they have several sections—

JUDGE GIBBONS: Mr. Ferleger, before the doctor refers to this document, will you have it marked for identification?

MR. FERLEGER: Certainly, your Honor.

(Above referred to manual entitled, "Psychiatric Facilities Serving Children and Adolescents," was marked plaintiffs' Exhibit 7 for identification as of this date.)

JUDGE HUYETT: What is the exact description?

(28) MR. FERLEGER: That is the "Accreditation Manual Serving Children and Adolescents," copyright number 1974, and paid for by a grant from the National Institute of Mental Health.

I think that a reference to the law regarding Medicare and Medicaid provisions will show that these standards are adopted by the Congress as the standards of Medicare and Medicaid aid to Hospitals.

JUDGE GIBBONS: Have you seen it, Mr. Roth?

MR. ROTH: I have only seen it briefly.

Of course, it is not being introduced into evidence. So we reserve objection to that, your Honor.

Continued Direct Examination by Mr. Ferleger:

Q. Are these standards generally accepted by child psychiatrists and proper standards for care of children in facilities?

A. Yes, and throughout this they make a distinction between the standards that shall be made and those standards that ought to be met. So, it is both a standard, plus a guide for the kind of improvement that should be implemented.

Q. What do they say with regard to due process and legal advice for children?

A. "The psychiatric facility serving children (29) and adolescents shall know the dignity and protect the rights of all its patients and their families. Every effort shall be made to safeguard the legal and civil rights of patients and to make certain that they are kept informed

of their rights, including the right to legal counsel and all other requirements of due process when necessary."

Let me add the reason I became involved with this, because I am setting up a day hospital at this moment and as a part of the budgeting for that facility, there is the budgeting for an attorney involved to provide the help to children in this facility?

MR. FERLEGER: No further question.

JUDGE GIBBONS: Are you going to offer that document?

MR. FERLEGER: No, I am not, your Honor.

JUDGE GIBBONS: All right.

Mr. Roth?

MR. ROTH: Your Honor, would you indulge us for just a moment, please?

JUDGE GIBBONS: Yes.

MR. ROTH: Thank you.

Cross-Examination

BY MR. ROTH:

Q. Dr. Kandler, would you please indicate what experience (30) you have and the duration of that experience in admitting adolescents?

A. I have been affiliated with the in-patient services of Bronx Municipal Hospital Center for 16 years and while being on that staff I was for five years supervising psychiatrist at Bronx State Hospital.

Both of these facilities are run by the Albert Einstein College of Medicine, so it is possible to have responsibilities in both areas.

Q. Would those facilities be considered an institution?

A. I'm not sure of the medical definition of institution. Certainly the State Hospital would be considered an institution. The other is a city hospital with a large psychiatric facility.

Q. The ones you work with are the city hospitals?

A. And for five years a state hospital.

JUDGE GIBBONS: Both in-patient facilities?

THE WITNESS: Yes.

Q. What was your role at the institution when you worked there for five years, were you the admitting psychiatrist of adolescents and juveniles?

A. I was first of all assistant director of a 3-ward unit which we used for training purposes for our residents. As such, there were five residents on my ward. I was responsible for the ward and I supervised them with all (31) their cases on the ward.

Now, in that particular instance, we didn't do particularly the admission, but when they were referred to us, we screened them. In other words, they would have often been at the city hospital and we would select them as being appropriate for this facility for their treatment. So, it was a selection process, rather than an admitting procedure. They were rarely admitted directly to the service, although at times they were.

Q. Do you believe in institutionalization?

A. I don't understand the question. In what regard?

Q. Well, in the sense, Doctor, that you testified with regard to out-patient treatment as well as in-patient.

Do you believe placing one into an in-patient residential facility, and in the State of Pennsylvania, a state mental hospital?

A. I think there were instances where patients have benefited from hospitalization.

Q. Now, Doctor, with regard to some statements you made, you indicated that a lawyer should see a juvenile; is that correct?

A. I think it is very helpful, yes.

Q. When do you think the lawyer ought to see the juvenile?

A. Well, I think there are two instances.

(32) One is before someone is hospitalized and one is after.

I think before one has to be very careful to be able to admit a patient quickly when a patient is in danger of hurting himself or someone else. There has to be some emergency way of taking care of someone who is in acute psychological difficulties. It is something that has to be planned and if there is an objection by the child, I see no reason why this could not be done before hospitalization.

Now, what happens is that one of the problems with psychiatry is that its prognosis is difficult and certainly predicting future behavior is most difficult, so I think it is very important after someone is admitted that legal help be available to someone after they are in the hospital.

Sometimes somebody is upset for a couple of days and then they improve and in a time like that if they are not easily discharged, they ought to have some recourse available.

Q. With regard to the manual which you read parts of on accreditation standards and recommendations, did that manual indicate if a hearing should be held for a juvenile prior to admitting into an in-patient residential facility?

A. Not that I recall.

Q. Doctor, would you please explain the admission (33) procedures there, with regard to juveniles?

Let me be a little more specific.

May a juvenile be admitted by a parent in New York?

A. Only a doctor can admit a patient to the hospital.

Q. May the parent make application for admission of the juvenile to the hospital after the doctor has recommended hospitalization?

A. Yes, they may.

Q. Is there a hearing afforded to a juvenile prior to his hospitalization?

A. Well, that's an interesting question.

It is not excluded, but I have never come across it in the order of events of admission.

Q. Well, Doctor, let me ask you this:

You have testified with regard to the admission procedures in New York in some terms and I am just asking you, do you know from your experience, if it is in fact in law that a juvenile is given a hearing prior to admission?

A. He is not given one, but I think—I personally think, it would be possible for a child to ask for one under the way that I read the law, but this is not my area of competence.

Q. Doctor, do you feel qualified upon evaluating a (34) young person to recommend a treatment for him or her or to recommend in-patient residential care?

A. After my evaluation, yes.

I may want other people to help me in that evaluation.

Q. Do you feel you need a corroborating opinion before placing a youth into any program?

A. Not necessarily. No.

Q. When a juvenile comes to you and I would assume—

MR. ROTH: Strike that, please.

Q. Let me ask you this.

Does a juvenile who needs help, let us say, come to you generally through his parents?

A. That would probably be—with his parent, not necessarily through his parent.

Q. With his parent?

A. Yes.

Q. When the parent and juvenile—

A. I mean, I want to elaborate that.

Very often it may be the child's wish to see someone and the parent acquiesces. Our problem is treating children who want treatment without the parents' knowing, not the other way around.

Q. When the parent is before you and the juvenile is before you, do you formally evaluate the juvenile?

(35) A. As well as the parent.

Q. Do you feel in some circumstances, it is important to review the parents?

A. Nearly always.

Q. Now, Doctor, how important is the family structure in terms of the development and growth of children?

A. What do you mean by "family structure"?

Q. For example, you have testified that some parents are reliable and they bring their child to an institution and you observe their behavior pattern and you testified that some are not as reliable and some are unreliable, and I am questioning how important is the family structure in terms of allowing the parent to seek this type of help for their juvenile—for their child?

A. I am still not sure of what you mean by "family structure".

Q. Doctor, I will take it from another avenue and I think it will clarify it more.

Do you think that parents generally operate in the best interests of their children?

A. Generally.

Q. Do you think that parents have a callous disregard for their children and are merely attempting to plop their children into institutions?

MR. FERLEGER: Objection as to the phrasing (36) of the question.

JUDGE GIBBONS: Overruled.

Q. Please answer the question.

A. It happens. I think the majority of parents have the best interests of their children at heart.

I think mostly where I am concerned about the issues that we are talking about here is—

Q. Doctor, I am sorry to interrupt you. I'd like—

JUDGE GIBBONS: That is a responsive answer.

A. I think some parents callously would like to get rid of their children, though the biggest number of chil-

dren who may not get the best possible treatment occurs where there is ignorance on the part of the parent.

Q. I'm sorry, I didn't get that.

A. "Where there is ignorance on the part of the parent."

Q. Do you feel there would be a conspiracy between parents and physicians and psychiatrists to place children into institutions?

A. No, I don't think so.

Q. Doctor, do you feel that most parents don't want to be separated from their children?

A. Most parents do not.

Q. Do you think that parents who have economic means and are able to doctor-shop in order to obtain treatment for their child without recommendations for institutionali (37) zation are better equipped as parents than those who come from poor socio-economic backgrounds and cannot doctor-shop?

MR. FERLEGER: I object to the question.

I don't understand the question, myself.

JUDGE GIBBONS: Do you understand it, Doctor?

THE WITNESS: I think I understand what he is driving at.

JUDGE GIBBONS: Objection overruled.

A. I don't think the variable is money. I think the variable is knowledge.

There may be some slight correlation between education and money. However, I think very few of us, when we are in trouble seek a second opinion. I think this is

a problem that is generally true. I think the population at large isn't discriminating enough in selecting all of their physicians.

Q. We are talking about the education and awareness of parents of meeting their children's needs, I would assume, and would you not feel that parents who perhaps may have a bit more education and are able to afford, if you will, more expensive treatment, generally doctor-shop, not necessarily to find one who will recommend institutionalization, but in order to find an evaluation (38) where they will not have to be separated from their child?

A. I think people doctor-shop to find a physician that agrees with them and that may be right or it may be wrong.

Q. Doctor, under—

A. As a matter of fact, there is a study that people overweight tend to go to doctors overweight.

And I think the same thing is true in psychiatry, that there are so many modalities of treatment that people try to find somebody who agrees with their opinion.

Q. Isn't that precipitated by the fact that parents do not want to be separated from their children?

A. That is not the issue at this juncture.

I don't think that that issue comes up. I think if they think about it at all, they are more likely to think they can't handle the situation, rather than worrying that the child would be forcibly taken away from them.

Q. Are you familiar with the procedure of parents making application for their children in Pennsylvania?

A. Somewhat.

Q. Would you please explain what you think the situation is for voluntary admission of children by parents?

A. The parent can petition to have the child institutionalized.

(39) Q. Do you know what the safeguards provided are for the screening of the child prior to institutionalization?

A. Prior to this case, there were none, but since this case, regulations have been set up that children from 13 to 18 can have legal advice, but there are no provisions for children under 13.

Q. Doctor, I do not think you have been totally informed about the safeguards.

With regard to juveniles, in order to get your opinion on whether or not this procedure is acceptable to you as a professional—

A. Juveniles at what age?

Q. It refers to youths from age zero to age 18. We are not restricting ourselves to juveniles or adolescents, but any juvenile 18 and younger, whether he is mentally retarded or mentally disabled may not be admitted to an institution until he is referred from a recognized medical facility, mental health, mental retardation therapist or mental health agency—

MR. FERLEGER: Mr. Roth is reading from the regulations and I must object.

JUDGE GIBBONS: He is laying the groundwork for a question and don't object until he asks the question.

MR. FERLEGER: His necessity to read it may also necessitate that Dr. Kandler have it in front of (40) you in answering the question.

JUDGE GIBBONS: Bring it up and let the witness look at it.

MR. ROTH: May we have a moment, please?

JUDGE GIBBONS: Are you referring to annex "a" to title 55?

MR. ROTH: Yes, I seem to have it attached to something—

JUDGE GIBBONS: I have handed him our copy.

Q. Can we look at page 1 and under numbers 1 and 2, it indicates how juveniles are, if you will, reviewed prior to their ultimate admission into an institution and in a form of summary, what basically occurs is that there is a referral unit and that referral unit be an individual therapist or a base service unit in Pennsylvania who will evaluate the child and we assume total evaluation of family, et cetera, in order to come to a disposition of whether or not the juvenile or child should be afforded admission into an institution.

Subsequently, the parent takes that child to the institution which is recommended by the referral unit and the director at that institution causes an individual examination to occur.

Now, at that point, if the individual examination corroborates the first, then admission is (41) made of the juvenile by the parent.

Now, do you think, since you have already testified that you feel confident to make a recommendation to either institutionalize or recommend mental treatment for a juvenile, do you think their screening devices are appropriate?

MR. FERLEGER: Objection, your Honor.

The question is not making recommendations. Dr. Kandler had not been asked whether admission should occur on a recommendation of his or anybody else's.

We don't question the right of referral agencies to make recommendations. All we question is who the decision maker should be.

JUDGE GIBBONS: Overruled.

You may answer the question.

A. The procedure sounds very good on paper, but unfortunately, there is a large gap between outlined procedures and the quality of the kind of evaluation the patient gets and my concern is with that quality.

I don't know the details of what the examination consists of. It isn't spelled out at all in this regulation. It can be a five minute chat with someone. I think it is good as far as it goes, but the only way for me to judge whether the procedure is good, I would have to know the people who are making the (42) examination, what kind of tests are done and so forth.

Q. Well, Doctor, assuming—now, assuming that the evaluation is done according to, if you will, generally accepted principals in psychiatry, would that satisfy you?

A. It would satisfy me.

I would have one worry about it and that is even carefully done psychological evaluations, the prediction of behavior is rather limited. People change and an evaluation takes a couple of months and it takes another month to get someone into an institution and there might be a vast change in an adult or child for that matter and I don't think it is enough for this evaluation to have taken place before hospitalization.

I think after hospitalization, equal care has to be taken and there must also be alternative judgments available after one is hospitalized, especially one which deprives one of his freedom.

Q. This case does not involve the right to treatment. The plaintiffs have not made any allegation that treatment is not being afforded to juveniles—

A. I was talking about keeping somebody institutionalized. I think that should be reviewed periodically.

Q. Doctor, without going far afield, that is a necessary part of treatment.

(43) Do you not evaluate as part of your treatment process, a person prior to his admission to a facility as well as subsequently?

A. I do.

Q. Don't you consider that part of the treatment process?

A. Absolutely.

Q. Now, assuming again, Doctor, that although on paper, we do not have outlined what one must do, a psychiatrist or a base service unit or anything of that sort in order to evaluate a juvenile, but recognizing them for acceptable facilities, do you feel that that two-step process is acceptable to you in terms of the recommendation that may be made to the parents as to whether or not the child does need institutionalization?

A. It is difficult for me to answer that directly the way you put the question.

I know from experience that even though there are regulations that the criteria for admission to an institution varies widely from city to city. I know that is true in New York City.

It is better when you have more than one judgment. No institution ought to be forced to treat someone who they don't think belongs in the institution and therefore, the director or his delegate should judge (44) whether somebody ought to be in his facility.

It is hard for me to say this is adequate because so much depends on how this is done and I know from experience that the statistics for admission to equal facilities within the same area vary widely.

Q. If you felt that parents and physicians and psychiatrists are acting in sort of a conspiracy to place children into institutions and as I recall—

A. I found no conspiracy between the three of them.

I think at times families cannot handle their children and try everything possible to get people into a hospital without necessarily relying on expert advice and I think most of the difficulty comes because unfortunately, there are nowhere near adequate facilities to take care of those people who need to have care.

There is not enough staff to do the job the way it ought to be properly done and things are slipshod.

Q. Do you feel for example, yourself, as a professional, if I were to come to your place and if I had a child and brought that child to you and you evaluated the child and the child did not need institutionalization and I said, "I really want this child in your institution," would you put the child in the institution?

A. No, the parent would take the child to someone else, (45) presumably someone more prone to institutionalizing of children.

Q. Along with those procedures, we do have a procedure and again reading down the page and particularly,

I alert you to number 6, we do have a procedure where every juvenile, age 13 or older, is given notice of the reasons for his admission and he is provided with a telephone number of the person who made application for him, which, by the way, Doctor, is limited to a parent, guardian, a person standing in locus parentis and he will be afforded counsel if he objects subsequently to admission and you have testified according to your law, there is no law indicating a juvenile must be given a hearing prior to admission and that the J.C.H. standards do not indicate this should be done.

Do you think a juvenile should be afforded this type of procedure?

A. Here it states, "13 or older." It eliminates younger children and I would disagree with that, and, secondly, excepting emergency children, it is a dangerous thing to remove a child from his environment and family and so forth and I think if there is serious conflict between the parents involved, including objection from the child, I think the child ought to have some representation, whether it be a psychiatrist or lawyer of his (46) choosing and I think this will help the children at a future time, if the child is convinced that what is being done for him is in his interests rather than anyone else's. I think it will help treatment in the future immeasurably.

JUDGE GIBBONS: Doctor, you indicated that you disagreed with the cut of age of 13 for notice purposes.

Do you have an opinion as to at what age a notice provision would be meaningful?

THE WITNESS: Well, I thought about that question.

It is difficult for me to answer that. Thirteen is not a bad breaking point, because we arbitrarily divide adolescents and children. I think younger children need protection and I have been in contact with the deputy director of our Mental Institute Division and they are concerned about that because they are less able to make decisions and ask for help and they consider it a specific duty of theirs to look in on the situation in our children's ward.

As to the actual notification of a piece of paper, that would be an adequate breaking point, but some representation for these children should be made.

They are less able to object, to be able to get a second opinion.

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(47) *Cross-Examination Continued*

BY MR. ROTH:

Q. Doctor, with regard to the advantages of having a hearing prior to the admission of a juvenile, as I understood your response to that type of question from opposing Counsel, you felt that it is better to treat a child who is cooperative, rather than one who is uncooperative; is that correct?

A. Absolutely.

Q. Do you feel that by providing a hearing, where a judge might order a child to be institutionalized, that that is going to affect the child's attitude in cooperating with treatment?

A. It would be better if that were not necessary, but at times, rarely, but at times, a child has to, or an

adult for that matter, has to be institutionalized in order to begin the treatment.

The purpose of treatment is to make the child cooperate with the treatment.

In New York State, we specifically request—we are requested by the Mental Health Law that we reduce the degree of institutionalization. It is not good to have someone, except for an emergency situation, to be admitted against their will.

Q. Doctor, in your experience, do you feel that generally adolescents will not tell you when they are depressed (48) because they wish to avoid the entire affair?

A. Adolescents take a different form than adults.

I am not so sure that few of them complain. They won't call it depression. I think adolescents complain and complain a lot. Perhaps they complain more than adults. The form of their complaint will take other forms. Complaints about authority and school and parents and so forth. They will less rarely come in and say they are depressed, because depression as we know it in adults is something which really occurs more frequently with adults.

Q. Is it not true that juveniles have a reputation as being unmotivated for treatment?

A. I do not find it so.

Q. You do not find that juveniles resent authority and constantly are rebelling to types of authority?

A. To authority, yes. I think that is a part of growing up.

Q. Do you not feel that being admitted into any facility is a type of authority?

A. Well, that depends whether you do it voluntarily or not. The true sense of the word, not the way the law in Pennsylvania defines it.

Q. Do you know of any juveniles that really like the idea of going into an in-patient residential facility?

(49) A. Absolutely. In our wards we have more trouble discharging patients than bringing them into the hospital. They want to stay.

Q. Do you find that juveniles who are objecting are really not objecting in the sense of you and I saying, "No, I don't want to do something," but it is really a so-called plea for help in which they want somebody to help them?

A. That is sometimes true.

Q. Now, one thing I don't want this Court to be misled with, Dr. Kandler, and that is the fact that every child is recommended for institutionalization.

Now, don't you feel, for example, in your practice, what percentage of juveniles or children, rather, come to you do you not recommend for in-patient residential treatment?

A. In my private practice, it is very, very rare.

Our statistics at Jacoby Hospital—first of all, adolescents, some 30 to 40 percent of our adolescents that come to our service come from a Family Court. Out of the remainder, we admit between 20 and 30 percent.

So that means that 60 percent, 70 percent would be referred elsewhere—those that appear in our emergency room, 70-80 percent, rather would be referred (50) to your clinic or some other social agency. Twenty to thirty percent of those coming to our emergency room are admitted. Other facilities, however, this may be double that number.

Q. Doctor, with regard to the section we are discussing, we are talking about non-emergency commitment.

Now, you have already testified that you have some knowledge of the emergency commitment provisions in Pennsylvania.

A. Yes.

Q. Do you feel that every juvenile is a potential emergency situation?

A. Absolutely not. Every juvenile where?

Q. That is being admitted to a facility.

A. There are different facilities, different situations, different hospitals. I can't answer that.

Q. For example, I believe Mr. Ferleger indicated to you that a hearing is provided for an emergency commitment?

MR. FERLEGER: I did not.

MR. ROTH: Strike that.

I'm sorry.

Q. With regard to the 405 Commitment Section, it deals with an emergency provision and states, "One is dangerous to himself and others and can be detained without a (51) hearing—"

A. Yes.

Q. —I am asking you, with regard to juveniles, although their situation may not appear to fit those needs—to fit those limits, if you will, "being dangerous to self or other," do you feel, Doctor, that a juvenile may be a potential emergency situation if help is not given right away?

A. Are you asking whether a situation would get worse if someone is not admitted, even though if it is not an emergency?

Q. If he is not immediately treated.

A. That is possible, but he can also get better.

I have known instances where hospitalization has been put off and the need for hospitalization has disappeared.

Q. Don't you feel it could be traumatic for a juvenile to be in a hearing and all sorts of facts coming out about his need for institutionalization are before him?

Don't you think that could be traumatic for a juvenile?

A. It can be, but my experience has been that it is helpful for the patient to know what other people think of him, including diagnosis.

Q. Doctor, with regard to the entire procedure, where, (52) from my understanding, your recommendation is that a hearing occur prior to institutionalization, do you not feel—

A. I recommend it ought to be available. I think it ought to be avoided if possible, but it ought to be available.

Q. In other words, if there is a conflict between the juvenile and the parent, do you feel that a hearing should be given?

A. I think a hearing should be available to the person who objects to being hospitalized.

Q. Do you find any problem with giving that hearing after the person is hospitalized?

You know, precipitating—

A. I think hospitalization is a very serious affair and unless it is an emergency situation, this possibility ought to exist before.

I am interested in forcing the system to have proper care beforehand so a hearing won't be necessary, so all parents can come to the conclusion what is the best treatment for the patient.

Q. Let's assume that we use the safeguards we have in Pennsylvania, where somebody is screened at step one, the parents are evaluated and the child is evaluated and there are recommendations made to the parent and child, (53) unfortunately, the recommendation, if you will, cannot be anything other than institutionalization and then we go to step 2 and the child and parents are again evaluated by the psychiatrist and the recommendation is made that the juvenile should be admitted into the facility and the child is screaming bloody murder, he does not want to go, and do you feel at that time that the child should be permitted to be institutionalized by the parent and if the child continues to object, then he can be afforded a hearing and in accordance with what you said, all the processes, do you feel the legal processes have been satisfied?

A. By the definition, emergencies ought to be admitted and non-emergencies can wait.

There is no reason to make a decision about a child that may affect him immediately for months and years and perhaps for his lifetime. That decision does not have to be rushed into. I don't see why if you take two safeguards, you can't take a third.

Q. In other words, on one hand, you are saying that a hearing should be given and—

A. I think a hearing ought to be available if the parties concerned can't agree upon what the best treatment for this child is and that would include the child.

Q. When you say, "Parties can't agree," whom do you (54) mean by "parties"?

A. Primarily the child, of course.

Q. So, you feel that a child that is, let's say five years old, is well enough aware of his situation that he can even make a recommendation or a statement as to

what kind of treatment or where he should be placed; is that what you are saying?

A. I think a five year old child that complains of pain, I think it ought to be considered seriously. I don't think he is necessarily right, but he has a right to have someone look into that situation, whether it is a physical pain or mental pain.

Q. Don't you think that pain is being looked into by the psychiatrist?

A. Yes, but we all make mistakes.

Q. Are you telling me that psychiatrists make a large number of mistakes with regard to recommending any treatment programs for a child?

A. I don't think it is large, but I think it is considerable and if it is you, I think it is very important.

Q. Do you make a lot of mistakes?

A. I hope not. I have made some.

Q. Now, Doctor, how essential do you think the role of the family is in terms of having a parent admit his child? Do you think that it is important for the parent (55) to be able to admit his child after he has received recommendations from phase 1 or phase 2, that is, the two steps, if you will, that is recommendations by professionals that the patient be institutionalized, do you think it is proper for the parent to be able to admit the child at that point?

A. Yes.

Q. Doctor, do you feel—

A. I mean, it is important, but as I said before, if it is not an emergency procedure, it is not so important that one need to ignore a child's objection.

Q. Aren't there ways of dealing with a child's objection, other than having a hearing prior to admission?

A. I hope so. The best situation is to get a child to cooperate with the treatment and believe in the treatment.

Q. Let's assume this: Say a parent—you just testified that the parent should be able to admit the child at that point.

What if the child objects to that?

A. You didn't ask me that.

Q. I am asking you that now.

What if the child objects to the parent admitting him?

A. I think the child ought to have someone that he feels is on his side, some professional, whether it be (56) a psychiatrist or attorney, if it is a legal question.

Q. I asked you before if you felt parents operated in callous disregard of the best interests of their children and you said that parents are [not] really operating in disregard for their children's interests.

A. I don't think I can make a general statement like that. I think it happens at times. I think the instances that mostly come to my attention where there are good intentions, but bad results.

Q. So then, Doctor, would it not be fair to assume that if there are abuses of this sort occurring, that perhaps, the way to deal with those abuses is to make sure that the evaluating psychiatrists are not, if you will, making errors in terms of evaluating the parents and the juvenile?

A. There is no question that we should have more psychiatrists and the best possible trained psychiatrists and unfortunately that is not true now.

Even the best psychiatrists make mistakes and there have to be secondary opinions available in medicine as there are appeal provisions available in the law.

Q. Doctor, what we have here is we have already two psychiatric opinions, if you will, in step 1 and step 2 and let's say the child—would you recommend another (57) psychiatric opinion?

How many psychiatric opinions would you recommend prior to admitting a child into an institution?

MR. FERLEGER: I object.

He already testified that he thinks a legal hearing is the best thing and I think this is getting redundant.

A. Well, I will add something to that.

JUDGE GIBBONS: One moment. Objection overruled.

A. It is very difficult to talk numerically.

What I am most concerned with is that the child have someone that he feels is there for his interest and not for his parents' interest or some school interest or social agency's interest or anyone else's interest.

How this is done procedurally can be done in many different ways, but I think it is important; quite apart from reaching a valid psychiatric judgment, you have to have the trust of the child. That includes a measure of confidentiality. A child can't possibly believe in you and confide in you, if the result is going to be that the psychiatrist isn't going to work with the child, but is going to work with the parents' recommendation that the child has no part in.

Q. Don't you feel that children are comforted and feel (58) loved and cared for by their parents?

A. We are talking about instances where the family structure has been disrupted. We are talking about instances—

Q. I am not talking about—

A. You are not talking about the normal family.

JUDGE GIBBONS: Can you give us some indication how much longer your cross-examination is going to be?

MR. ROTH: I think perhaps 15 minutes.

JUDGE GIBBONS: I think the court reporter would appreciate a recess at this time.

(Whereupon, a recess was taken.)

(All Counsel and parties being present, the following transpired in open court.)

JUDGE GIBBONS: Back on the record.

(Witness resumed.)

MR. ROTH: Your Honor, may I have the last question read, please, by the court reporter?

JUDGE GIBBONS: Mr. Reporter, would you read him the last question?

(Whereupon, the above requested portion of the record was read by the court reporter after which the following transpired in open court:)

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(59) *Continued Cross-Examination*

BY MR. ROTH:

Q. Doctor, do you feel that if you have an adversary process between—or if you have a proceeding whereby the juvenile can be given a hearing prior to the admission by the parent, don't you feel that the adversary relationship that is created between the parent and the child

will ultimately be disruptive to that family's structure in the event the child is ever returned to the family again?

A. I can't see how the fact of the hearing will make it any worse than it is, since obviously the disagreement exists before the hearing.

Q. What if a parent wants to put a child into a general hospital and the child is objecting there and the parent prior to putting his child into a general hospital has had the child evaluated by two or three neurologists and the child objects at that point; do you feel there should be a hearing?

A. I have very little experience with that kind of a situation, but it is my belief that that ought to be available. I don't think it would happen very frequently, but as I have said before, we all make errors and I think in an extreme situation that ought to be so.

Certainly I have known many instances where children have been forced to submit to something that was (60) unnecessary.

Q. Doctor, is it not one of the, let us say, legal requirements for parents to seek medical care for their children when they need it?

A. Yes.

Q. Do you not feel that parents who can't seek medical care unless they have to take part in a judicial proceeding, that they will not seek medical care?

MR. FERLEGER: Objection.

Unless you can define what he means by medical care. He has not testified to medical care—

JUDGE GIBBONS: He just did. He testified to a question about a neurological problem.

MR. FERLEGER: I want to make it clear that this case in the complaint or anywhere in the record that nowhere do we allege that neurologists need a prior hearing.

JUDGE GIBBONS: The question is the availability by a hearing device, would that tend to discourage parents from seeking medical or psychiatric assistance?

A. As a psychiatrist, it is my judgment and my experience that if a family can't work out situations such as a child going into a hospital, then there is some difficulty in that family. It may not necessarily be of any major proportion, but I would think it would occur very (61) rarely that a young child would go to court, but I think that possibility ought to exist.

I think that people do get unnecessary surgery; I think parents get involved with fads, with all kinds of quack treatments and there should be something available in an extreme situation that a child should have someone else to turn to.

JUDGE GIBBONS: You haven't answered the question.

Would the availability of this hearing device tend to discourage parents, if you will, parents in families where there are problems, from seeking assistance for their children?

A. I don't see why it would, because I think the issue of a hearing does not come at the point where you seek advice and help. It usually comes after you have gotten the advice and help. I don't see how it could.

Q. Then, Doctor, is it my understanding that anytime a parent wishes to obtain medical care, by the psy-

chiatric or non-psychiatric care for his child and there is an objection by the child, then, you would handle that by doing what plaintiffs' recommendation is, by having a hearing prior to admitting that juvenile or child into a hospital; is that correct?

You would have a hearing in every (62) circumstance?

A. At that juncture, I would try to persuade the child as to what is involved and what is necessary and why it is necessary. If it is not sufficient or if I am identified in the child's mind with the parents, I would see the child has a chance to talk with an expert who has not been involved in the proceedings up to that point and after that, I would think a hearing or legal representation in some way certainly would be helpful and would be helpful to the child psychologically in terms of his accepting the procedure to be performed and it certainly would make his cooperation more likely, which might be very necessary in some forms of treatment.

Q. Would you say that hearing would make the child more acceptable toward the ultimate treatment?

A. It may.

Q. Do you have any statistics to reveal that it would?

A. I do not. I have some experiences, but no statistics that would be meaningful in a large context.

Q. Do you feel there to be any stigma attached to having a juvenile undergo a hearing prior to admission, where he is now court ordered to a mental health facility?

A. No, I don't.

Q. Why not?

A. Unfortunately, there is a stigma being attached to (63) being in a hospital, which would be another reason

why all care ought to be taken before this type of drastic step be taken. I never heard the fact that a judge or attorney being involved in a proceeding increases that stigma.

Q. Doctor, do you realize what the nature of this lawsuit is doing, that it is going to have juveniles or children, we have not distinguished ages, that they will be treated the same as adults?

Do you feel that children are—you say zero to 18 should be treated the same as adults?

A. Yes, I do, in this regard that you are talking about. I certainly do.

Q. Do you feel that there are not developmental differences between a 19-year old and a 1-year old?

A. I certainly do.

Q. Do you feel that one who is an adult is generally more aware due to his experience and development to seek treatment if he needs it, than perhaps one who is age three or four?

A. Well, one has to be very careful about what age you are talking about.

Certainly in general, one's judgment increases over the years. By and large adolescents may have the kind of judgment that is required of adults, (64) although I think the issue of the way we develop judgment, it continues for many, many years. Someone who is four or five may have better judgment than one at twenty-one. It is arbitrary as to which you make the breaking point in terms of age.

If someone objects or thinks he has an objection, it is important to take that seriously. It is not necessarily true whether one is right or wrong.

Q. Have you discovered the percentage of cases in New York where juveniles are admitted incorrectly? Do you have any idea as to that?

JUDGE GIBBONS: Admitted now to a psychiatric residence facility?

MR. ROTH: In-patient.

A. I have no idea incorrectly, because presumably, if they were admitted incorrectly—there are two aspects of this, whether psychiatrically incorrect or whether when a hearing is requested, the Court rules that they ought to be discharged.

That happens quite frequently with adults. Our experience with adolescents has been this way:

The mental health review service has operated for several years and to the best of my knowledge, there has not been a hearing. That is important as to what you are asking, whether five-year olds will clog (65) up the courts and so forth.

I cannot recall an actual hearing taking place with an adolescent, someone that was not referred to us from the courts, I am talking about, because the attorney in discussing the rights and the issues with his client usually helps him to negotiate in some way with the psychiatrist to find some way for the treatment to continue.

Now, at times treatment does not continue with discharged cases where our advice has been that a child should remain in the hospital, but we didn't feel it was an emergency situation. We felt at this point it was better for the child to leave the hospital.

Very frequently they come back and they request clinic care and that treatment is usually much better than if one continues to keep a child in a hospital forcibly.

Q. Are you saying all your admissions are pursuant to court order that you have dealt with?

JUDGE GIBBONS: He did not say that.

A. No. What I was referring to was some 30 percent of our cases come from Family Courts where the Court has been involved rather than from social agencies or walking in by themselves.

Q. And the remainder of those does not involve any (66) court proceedings?

A. That's right.

JUDGE BRODERICK: Of that remainder, would you have any idea of what percentage of the admissions were based on an emergency situation?

THE WITNESS: Well, it is the majority. I would guess that 80 percent, maybe more.

JUDGE BRODERICK: Eighty percent are emergency situations?

THE WITNESS: Yes.

JUDGE BRODERICK: If the 80 percent are emergency situations, what part of the 20 percent would be as a result admitted pursuant to a court order?

THE WITNESS: I don't know of any instances where there was a court involved beforehand purely on the basis of the advice of the physician.

We do have that 80 percent that comes to the Family Court that comes from a court order, but that

other 20 percent, they are voluntarily admitted, where the doctor and patient works out that they should be in the hospital.

Q. Of that 80 percent that require emergency treatment, what do you mean by "emergency"?

A. That a child is judged to be immediately in danger of himself or to others.

(67) Q. Are there any provisions in New York law that permit somebody to be detained?

A. Yes.

Q. Why weren't they admitted pursuant to that section?

A. It is usually felt that that is a rather—first of all, some of them are.

Q. For those who are not.

A. Those who are not, we are incumbent to try to admit people and put people on the least stringent form of restraint, so that if someone comes to our emergency room or agrees with the doctor or says it is all right for them to be in a hospital, we will admit them on a voluntary basis.

There is even a provision in New York law that is even less formal than voluntary, informal basis where a patient is admitted where there are no legal records that the patient is admitted and I think the more we have of that, the better kind of psychiatric care we will be able to give the patient.

There are patients who need to be in the hospital under restraint. It is much better to get the patient to cooperate and all treatment is geared towards making the patient cooperate.

JUDGE GIBBONS: Is there any procedure in the hospitals that you have been affiliated with where (68) juveniles can voluntarily admit themselves without parental admission?

THE WITNESS: No, they can get out, but they can't get in.

Q. Are you aware of any situations in Pennsylvania where juveniles have been admitted inappropriately into state mental facilities?

MR. FERLEGER: Objection, he is not qualified on the situation in Pennsylvania.

JUDGE GIBBONS: The question now is, is he aware and he may answer that yes or no.

A. I don't know of any cases at all in Pennsylvania.

Q. Doctor, do you often testify in court cases?

A. No, I do not.

Q. Are you being compensated for your testimony today?

A. Yes, I am.

Q. How much are you being compensated?

A. Two hundred dollars—I am charging—that is my bill.

MR. ROTH: Your Honors, I have no further questions.

JUDGE GIBBONS: Any redirect?

MR. FERLEGER: Just one question.

Redirect Examination

BY MR. FERLEGER:

(69) Q. Just one question, Dr. Kandler.

With regard to the various percentages that have been discussed, you testified that in your facility, the number of children admitted, pursuant to, I believe you said, the voluntary provisions, admitted as an in-patient may be less than half of those at other facilities.

Could you explain why other facilities may be admitting many more juveniles than you would be?

A. Well, I can't talk specifically about juveniles, but we did a study with adults a few years ago, comparing our facility and I think it will answer your question, also.

I don't have the specific answer for children, but this included all admissions which included some children, but I don't know what the breakdown is and we compared our admissions with the Bellevue Hospital, because of some administrative—the situation—what happened was, that all the patients from Lincoln Hospital were all technically admitted to our hospital and their hospital. They were judged by Lincoln Hospital psychiatrists to need admission in a psychiatric facility and Bellevue and we would make individual decisions whether we agree with them or not.

After this initial screening, we only (70) admitted some 50 or 60 percent of those patients while in Bellevue over 90 percent were admitted.

Q. Why would that difference occur?

A. The difference in philosophy, the amount of help available and the amount that could be placed in the facility.

Q. So, you disagreed with the initial admission in a little more than half of the cases?

A. Yes.

Q. And in Bellevue they disagreed sometimes, and then sometimes they did not disagree?

A. That's right.

We had clinics available; we had day hospitals available; so that obviously sometimes, you hospitalize someone because that's the best alternative for the patient at the time although it is not a good one and at our facility where there were other alternatives possible, some did not have to be hospitalized.

There was no disagreement about the diagnosis or pain or trauma, but we had other means available.

MR. FERLEGER: No further questions.

MR. ROTH: Just one question.

Recross-Examination

BY MR. ROTH:

(71) Q. You said no other alternatives were available. My question is:

If a child is recommended for institutionalization, don't you think that normally occurs after all other treatment modalities are explored by the examining psychiatrist?

A. That is such a general question, I can't answer it.

In some places a psychiatrist will be careful about it and in other places he will not. I don't know how I can answer that numerically in a way that would be meaningful. He should.

MR. ROTH: Thank you.

JUDGE BRODERICK: Doctor, you indicated from your testimony that you were concerned about the possibility that a juvenile may end up in in-patient care that did not belong there. Let me ask you this:

Do you think that it would be sufficient protection if the child who objected were given the opportunity to get an individual psychiatric evaluation?

THE WITNESS: I am not sure I understand how to answer that.

That would be preferable for a step. So often, children find themselves dealing with people who do not represent them and as I said before, with psychiatric issues it is most important that trust and confidence (72) be established not only for treatment purposes, but for relation purposes and what happens beyond that is a legal question which is difficult for me to answer.

You are posing a question if what would then happen if the child disagreed with his own consultant.

JUDGE BRODERICK: Would you think a preadmission hearing would be necessary if the individual psychiatrist had agreed with the other two evaluations or that as the attorney for the Commonwealth indicated was usual in these cases?

THE WITNESS: From a psychiatric point of view, I would be happy and satisfied if a child could have a psychiatrist of his own choosing or some one individual. For the legal requirement I am not sure

I can answer that question as to what would be sufficient.

JUDGE BRODERICK: I am not asking you to answer the legal qualifications. I am asking you whether you see any value to a legal value where the child who objected had the opportunity or an evaluation by a psychiatrist and who agreed with the others there should be in-patient care for that child?

THE WITNESS: I am trying to imagine the ramifications as to what would happen. Obviously, if there is a hearing, the hearing could be wrong, too.

Whether it is a psychiatrist or more (73) formal hearing situation, there could be an error.

I would have to say just as though there can be an appeal from a hearing, there ought to be some appeal at some place.

JUDGE BRODERICK: Even where you have the individual psychiatrist agreeing with the other two, you feel there is an advantage to having a full hearing?

THE WITNESS: There is just too much chance to error and I would agree, it is something that could affect the large segment of a person's life.

Even with a child, even a couple of months is a tremendous area of his life. It has ramifications because children grow so rapidly.

JUDGE BRODERICK: Have you in your experience in New York ever been confronted with a situation where the parents of a child wanted the

child to be admitted for in-patient treatment and you thought that in-patient treatment was not necessary?

THE WITNESS: That happens frequently, of course, where a parent must say, "I really think the child should be in the hospital." What happens usually, we work with the family as well as with the children and most of the time, some agreement is reached where the child should or should not be in or some other form of treatment should be instituted whether the child should (74) be in the day hospital or in the clinic, so that is the goal of treatment to get everyone working together and the precipitating event to that situation is something that has to do with the parents and with the child as well.

Most times parents say, "I want my child hospitalized," and we say, "It's not necessary."

JUDGE BRODERICK: Are you saying most of the time a parent wants in-patient treatment for a child—

THE WITNESS: I was thinking where a child is brought to the emergency room.

There is a big difference where a child is brought to the emergency room or to the clinic and parents do some preliminating sorting. If they bring the child to the emergency room, they have in mind that they wish somebody would take this child for a while. It is not an unknown idea in a parent's mind. Very often we disagree with that and try to find some other solution to the problem.

JUDGE BRODERICK: In such a situation where you don't disagree, is it your opinion that error has been made in your experience in admitting such a child to in-patient treatment?

THE WITNESS: Well, I thought about that question. It is difficult to answer because presumably (75) if I reach the decision, I don't know whether the error is being made. I presume it is not being made and unless for some reason someone else looks into the situation and disagrees with me at that instance, there is no real way of checking on that.

What I have seen is that many times within a day or two, a child is quite different and even though perhaps at that particular moment in the emergency room, it was necessary to place some restraints on that child and that is one of the problems.

I think psychiatrists make good diagnoses, but their prediction of behavior holds up for a short period of time and it has to be reviewed.

There is one instance that comes to mind of a child that was hospitalized and this was a personal patient of mine when I was in training in the hospital who had been in the hospital for several months and I wanted to discharge this child.

As a matter of fact, not even home, but to a residential treatment center and the mother wanted the child to stay in the hospital and refused to give the child clothes. I sent the police to the home to pick up the clothes.

JUDGE BRODERICK: In that situation you had no problem except for the lack of cooperation of getting (76) the child out of the hospital.

I have no further questions.

MR. FERLEGER: Thank you, Doctor.

(Witness leaves stand.)

(77) MR. FERLEGER: Plaintiffs call Michael Ingall to the stand, please.

MICHAEL INGALL, sworn.

THE CLERK: Would you state your full name?

THE WITNESS: Michael A. Ingall.

THE CLERK: Thank you, be seated.

Direct Examination

BY MR. FERLEGER:

Q. Doctor, what is your occupation?

A. I am a psychiatrist.

Q. Would you state for the record your current affiliations?

A. I am the medical director of the Providence Health Center in Providence, Rhode Island, which is a mental health out-patient unit.

I am also clinical professor of psychiatry at Brown University School of Medicine.

Q. Would you please state your background as briefly as you can in psychiatry especially with reference to children and legal matters?

A. I am a graduate of the Chicago Medical School. I did three years of residency at Boston University Medical Center, one year of which was a Fellowship in child psychiatry which was spent at various psychiatric (78) facilities in Boston, one of which was the Roxbury District Court Clinic, where I served as a consultant to the Court, seeking alternatives to in-patient institutionalization or jail for people who were before the Court on drug related offenses.

Most of them were adolescents and we sought community based out-patient treatment or residential treatment in a half-way house for them.

Q. Doctor, have you been the recipient of any awards or honors in your field?

A. I received from the American Psychiatric Association a Faulk Fellowship, which is an honor.

I am a member of Alpha Omega Alpha, which is an honorary medical fraternity.

Q. Are you certified by the American Board of Psychiatry and Neurology?

A. Yes, in psychiatry.

Q. Where are you licensed to practice medicine?

A. Rhode Island and Massachusetts.

Q. Doctor, with reference to your Curriculum Vitae which I will show you and this is marked plaintiffs' Exhibit 6—

MR. FERLEGER: I apologize. I have to call him out of order because of his airplane schedule.

Q. —is this a summary of your qualifications and (79) background?

A. Yes, it is.

MR. FERLEGER: Do you have any questions on qualifications?

MR. ROTH: No, I don't.

MR. FERLEGER: May I proceed, your Honor?

JUDGE GIBBONS: Yes.

MR. FERLEGER: Thank you.

Continued Direct Examination

BY MR. FERLEGER:

Q. Dr. Ingall, I wonder if you could discuss just briefly the general question of the sources from which children's emotional difficulties arise and what the relationship is between that and the family structure that Mr. Roth has been talking about?

A. In my opinion, most of the children whom I see, most of the young children and adolescents whom I see, what emotional problems they have usually is a function of intrafamilial problems, that the problems of the children are manifestations of problems that go on within the family.

There are occasional psychiatric problems that tend to be psychoneurological in character which are perhaps not stemming from intrafamilial conflict, but which in and of themselves often give rise to intrafamilial conflict because of disagreement of the management (80) of the child and home.

Q. Is it your opinion, then, that it is the family that has problems or is it usually the presenting child that has the problems?

A. Well, I would say with most of the kids and adolescents that we see at our clinic, most of them are brought by parents or come with parents. Usually, they come at the suggestion of a school or court, the presenting complaint being not that of the child, but of the parents, saying, "My child is doing such and such. I would like you please to fix him."

Q. In those situations, can you explain why the child, rather than another member of the family would be the one who would be identified in the role of the patient?

A. I think it is because children are little and are in a subordinate position with regard to their parents.

If a parent decides the kid is going to go to a psychiatrist or is going to go to a hospital, the child's objection does not carry the weight that an adult of equal stature would carry. It is much easier to hospitalize a child if you are an adult than it is your brother.

Q. In those situations, Doctor, with what frequency have you found that parents suffer from some emotional illness as well as the children they seek to be put into (81) treatment?

A. Frequently and—

Q. You may explain.

A. As I said before, if we have a child or adolescent who is presenting in this way, one of the early goals in treatment we have is to see the family, either to go as a family unit if things are not too chaotic or at least to see the parents separately from the child, in order to get the focus of the kid as a scapegoat as to what we see as intrafamilial problems to try and get the family working together.

Even if the family says, "You have a problem; how can we help," that is better than saying "You have a problem; go get it fixed."

Q. Do I understand that you said that the child is at times the "scapegoat" of the family's problems?

A. Yes, it's a strong word. I don't use it myself.

Q. Doctor, I wonder if you could give us your opinion with regard to whether or not in a non-emergency situation, there ought to be a judicial hearing prior to the commitment of a child to an in-patient mental institution?

A. I think there should be. I think particularly so in the case of a child. An adult or an older adolescent has the capacity and the maturity to make his own case, either to the admitting psychiatrist at a state hospital (82) or to an examining psychiatrist at another facility and he can convince, perhaps, that psychiatrist that he should not be hospitalized. He can say, "Look, they want to put me in the hospital because my mother wants to go out every night." He can say, "Father wants to put me in the hospital because he is jealous of me."

He can make a convincing case for himself. A younger child often does not have that capacity and he may not be able to say, "Look, okay, I need treatment, let me go on an out-patient basis." He may not know what resources are available to him as an alternative.

Q. What function do you think the hearing could have in that kind of situation?

A. I think in that situation the child would have an advocate who was clearly representing him who would explore with experts, if necessary, alternatives to hospitalization and would review the need for hospitalization, which is for me a last resort.

Q. Can you give us your opinion on whether or not you feel there would be any trauma or any adverse psychological effect on a child of having such a hearing in the child's behalf?

A. I think there would not. I think if the situation is such that a hearing must be arrived at, that the parents and child are in such conflict, that this must (83) ensue, that there already is severe parent-child conflict and disruption between the family and that such a hearing can certainly do no further harm.

I don't think it is harmful to a kid to hear what a psychiatrist or anyone else has to say about him and I don't think it is harmful to hear diagnostic terms bandied about.

Q. In that situation that you are describing where there is family conflict or at least, disagreement, do you feel that the parents are in a position to judge the best interests of their child and what kinds of treatment the child ought to obtain?

A. Well, even when there is family conflict, often, it is the case that parents do want what is best for the child. I think it is an unusual circumstance when parents are really adversaries of the child.

Even however when parents want what is best for their child, sometimes their judgment because of their intimate involvement with the situation and very emotional strong feelings that they have about their kids which is natural, often then, their judgment is not the most objective.

Q. Are there occasions—

MR. FERLEGER: Strike that.

Q. In the context of a family that is seeking (84) institutionalization for a child, have you had any experience with misinterpretations of a child's behavior by members of the family or by psychiatrists that the family has sought out?

A. I got hung up on the word "institutionalization" and that means something different than the word "hospital".

Can I elaborate on that?

Q. Yes.

A. For me, institutionalization has a negative connotation. There are many institutions, a college is an institution, this Court is an institution, a psychiatric hospital is an institution. When we talk about the negative effects of institutionalization and we usually talk about the negative effects rather than the positive effects of institutionalization, we are talking about a situation which is usually a detrimental one, so I am opposed to institutionalization, voluntary or involuntary, and I am very much for hospitalization when adequate treatment is available and I realize it is not a right-to-treatment suit, but I think there is a difference.

Q. When a child is to be placed possibly in an inpatient facility which may be detrimental or may be positive, in your terms, are there problems with the psychiatrist, that they are relying on simply the parents for the factual information upon which their decision is (85) based?

A. Sure, everything that you hear from a patient or his family is given with a bias. We all try to present ourselves in the best light we can.

Q. Do you feel that you, as a psychiatrist or a judicial officer at some sort of hearing should be the person to resolve those factual conflicts?

A. Well, if you are talking about strict questions of fact, you know, did the child do this at such and such a date—

Q. Yes.

A. —Well, I think that the legal profession is much more adept at dealing with objective fact than the psychiatric profession, although sometimes I think objective fact is not as relevant as subjective emotions.

Q. Now, have you had any experience in working with Courts in terms of giving your advice on the medical end after the Court has determined the legal questions?

A. After the Court has determined the legal questions?

Q. With regard to a need for treatment.

Have you had any experience in providing input into what happens therapeutically to the subject?

A. My experience at the Roxbury District Court, my consultation with the patient or client occurred after an indictment, but before sentencing, so I would confer (86) with the judge prior to his sentencing of the client or defendant and then, the judge would decide whether or not to make treatment in the community an alternative to incarceration.

Q. Will you explain, Dr. Ingall, the reasons that you think as a psychiatrist, that it is important for there to be a hearing with an advocate representing the child's interests?

A. Well, if I have to treat someone who is involuntarily committed to me, that is possible. If I, however, am the one who, in the eyes of my patient, is incarcerating him within a hospital, then, I become (a) therapist, and (b) also jailer, and that is a confusing role for me and the

patient and it makes treating the patient difficult because it heightens the ambivalence to me.

I have treated patients who were submitted to me and the Court would say, "You have to go see the shrink or you go to jail," and the kid would come in and see me and I'd say, "Why are you here?" and he would say, "The judge said I have to be here."

I would say, "That's a sad situation and we have to meet together, so let's make the best of it," and we would form a therapeutic alliance in that way.

Q. And you feel it is difficult to form such an alliance if the psychiatrist is the one who certifies (87) the need of hospitalization for the patient as in the state's regulations?

A. Unquestionably.

Q. Dr. Ingall, in the non-emergency situation where necessity for hearing might involve some delay of a week or two, perhaps, can you see any reasons, number one, that the delay should be so terrible that we shouldn't allow such a delay or, two, do you see any advantages to such a delay?

A. If it is a question of an emergency commitment where imminently a child is in danger of hurting himself or others. There should be provisions as there are in this and in most states for involuntary hospitalizations.

Q. In a non-emergency situation?

A. In a non-emergency situation I don't see any harm and I think there are advantages to a delay.

Children, as we all know, have a tremendous capacity to recover, to improve and to change.

You know, all of us know and perhaps remember ourselves when we were adolescents, one day you are

in love with a girl and you know, she is the end of the world and she won't have you and you are going to die. You are going to go out and kill yourself and the next day you meet somebody else and you are on top of the world.

Children are very fluid. Also medically, (88) a child admitted to a hospital or a child on an out-patient basis who is medically ill, may look as though they are on death's door and indeed be on death's door one day and the following day become completely well, running around.

Saturday, my daughter was home in bed, vomiting, pale, feeling awful, and Sunday morning she was running around outside.

Q. Do you think in terms of the psychiatrically ill juvenile, that the delay might help things? Is that what your testimony is?

A. Yes, I think hospitalization is a very serious step to take with an adolescent, child or an adult and if there is a waiting period in a non-emergency situation that things can change so by the time the hearing comes around, there is no need for the hearing. All are agreed that hospitalization is or perhaps things—or perhaps hospitalization is not needed or perhaps the situation deteriorates where people decide, the child included, he needs to be in the hospital.

Q. Can you please explain why you would wish to make a distinction between parents taking their children for treatment in an in-patient psychiatric institution as opposed to treatment by a neurologist or by a physician for a physical problem along some other basis?

(89) Why is a mental hospital such a different place?

A. A mental hospital is a different place, because there's stigma attached to it and because depending on the hospital, it can be a dangerous place.

There can be situations in which a child is exposed to other patients who are dangerous to him and if there is not sufficient staffing within the hospital to insure the safety of all, it can be a dangerous place.

Q. Is there any other way in which an institution can be dangerous?

A. There was an article in the Sunday Times yesterday about kids who were in a facility, who were being raped and extorted and they shouldn't have been there.

Q. Now, Doctor, with reference to the state's regulations which were adopted subsequent to the institution of this lawsuit and which provides for the possibility of a hearing for those 13 through 18 year olds after commitment, can you give us your opinion on whether or not such a proposed commitment hearing can be harmful to the psychological well-being of the child?

A. Whether the hearing can be harmful?

Q. Whether having the hearing after somebody is already in the institution might be detrimental.

(90) A. It is far more preferable to have the hearing before-hand.

Q. Why?

A. Because you may avoid the necessity of hospitalization in the first place.

Q. With regard to children who are, let's say, under the age of 10 or 11 or 12, who I think we can all agree might not be able to identify their need for an attorney or for a hearing, do you think there would be any benefits to a prior hearing with regard to those children?

A. Yes, I think if a child has a serious objection to hospitalization which cannot be overcome by talking with his parents and with a doctor on the outside, that that child is entitled to legal representation at a hearing, providing it is not an emergency situation, prior to the decision to hospitalize him.

Q. Do you feel that such a hearing or provision of Counsel would interfere with the treatment of juveniles by psychiatrists?

A. A hearing beforehand?

Q. Yes.

A. You mean if the child is later admitted to a hospital?

Q. That's right.

A. Would it interfere?

(91) Q. Yes.

A. No, I can't see that it would.

Q. Do you feel that such a hearing would be a substantial hindrance to the relationship between the parents and the child?

A. No, I do not.

MR. FERLEGER: Mr. Roth, your witness.

MR. ROTH: Thank you.

Cross-Examination

BY MR. ROTH:

Q. From your testimony, I understand that you are opposed to hospitalization until every other avenue has been explored; is that correct?

A. Generally, yes.

Q. Do you feel—let me ask you, are you familiar with our procedures? Were you in court today when Dr.

Kandler referred to "Annex 'a' ", about the additional safeguards?

A. Yes.

Q. Are you aware of the two-step procedures used in Pennsylvania?

A. For what?

Q. For the possible institutionalization of a child.

A. You mean under Annex "a"?

Q. Yes.

(92) A. My understanding is that a child must be taken to an outside facility, outside the hospital, certified there and certified at the hospital to be admitted and then on an uncertain date after admission, has a right to a hearing.

Q. Well, that part is true, but basically, I am just familiarizing you with it because I'd like to ask you a question about it.

The child is taken to a recognized agency or a private psychiatrist and a psychiatrist makes a recommendation, for, if you will, institutionalization and consequently, the recommendation, along with the parent and child, arrives at the institution and an individual examination is conducted and if that examination corroborates, agrees with the first, then, the child is institutionalized or recommendation is made for the parent and the parent may or may not institutionalize the child and once the child, age 13 or older, objects, the child is provided with Counsel and a hearing.

Now, you have stated and I don't think the Commonwealth is at all at odds with the statement, that hospitalization is a last resort.

Would it not be your professional opinion that based on this procedure, that the psychiatrist generally would

seek some form of treatment, other than (93) institutionalization?

A. Not necessarily.

Psychiatrists vary in their opinions as to the need for hospitalization. There are some psychiatrists who like to hospitalize most of their patients initially for a diagnostic workup.

I disagree with that. There is also a situation where a poorly funded, poorly staffed clinic in the community may be overwhelmed with the number of cases asked to treat. And it is a fact they have too many cases and the clinic may say to the parent who comes in, "Sure, as long as you don't bring them in," and they will acquiesce.

Q. Let's assume you have a clinic overworked and that is so because there are no other modalities of treatment for the child, so they recommend institutionalization and the director of that institutional place has an individual examination conducted, do you think the results of that examination will be the same as the first?

A. In the situation you outline where there is no alternative except institutionalize, I think that carrying with it the bad connotations that it carries is probably worse than leaving the child in the community.

Q. I inform you this is a case as to the challenge of the type of treatment.

(94) Bearing that in mind, the question remains, if no other form of treatment is available, whether it is in a county in Pennsylvania or in Wisconsin or where-have-you and the only way to provide treatment for that child would be institutionalization, would you be opposed to it?

A. Yes, I would, on the basis that two psychiatrists feel the child is mentally ill and that other resources being

unavailable, hospitalization must be resorted to and the child objects, then I think that child has a right to object and a right to a hearing and a right to Counsel to state that objection.

Q. Let's follow that out.

Assuming all those facts were as we have discussed, where there be no other form of treatment in that particular area and that the child were afforded a hearing and it was determined that the child does need a method of treatment which is unavailable and that form of treatment could be met at an institution, would you object to a judge finding or holding that a person should be institutionalized for that type of treatment?

A. If psychiatrists feel that only in a state institution is the form of treatment that is available that the child needs and the child objects and the case comes to a hearing, then I would hope that at that hearing it would be decided that despite the objections of the child, (95) he would have to go to that institution.

I am not opposed to involuntary hospitalization. I think there have to be safeguards against it, however.

Q. You don't feel those safeguards are available by permitting a hearing after the child has been committed?

A. That is one level of safeguard. I believe it would be better to have the hearing beforehand.

Q. You prefer a hearing beforehand but you are not objecting to one after?

A. I think anyone who is hospitalized involuntarily is entitled to hearings at various stages, be it a child or an adult.

Q. Now, you have indicated that parents who necessarily come to your facility are not in the best ways to assess the problems of their children; is that correct?

A. Some.

Q. Some?

A. Some parents.

Q. Don't you think the mere aspect of the fact that a parent brought his or her child to you presumes that the parent is acting in the best interest of seeking treatment for the child?

A. That is not always the case.

I have had a very significant number of (96) patients who have come to my clinic which is a sizeable one, where the purpose of bringing the child to treatment has been to accuse him, to punish him, to separate him from the home. The motivation is not always good. Usually it is, but not always.

Q. And, in those situations, how do you react; what do you recommend?

A. I recommend alternatives to hospitalization. I will recommend either seeing the family together on an out-patient basis as a family unit. I will recommend seeing the kid on an individual basis and seeing the parents separately, if they will agree.

Q. So, in other words, Doctor, wouldn't it be very difficult, again, referring to our regulations, that if someone came to you and you did not recommend institutionalization, it is going to be very difficult for that parent in order to put that child into the institution, wouldn't that in effect occur in Pennsylvania?

A. Could you repeat that?

Q. If we are using the two-step process and the parent comes to you and you feel the motivation of the par-

ent is not correct, and you do not recommend institutionalization, the parent won't be able to have the child admitted?

A. There are plenty of psychiatrists around, the parent can seek alternate opinions.

(97) Q. The parent would begin to doctor-shop, is that what you are saying?

A. Possibly. We had had within the past week a mother bring a kid to the clinic who had originally been to child welfare services, wanting her child placed, because of his behavior, in a sort of state institution for abandoned children; I am not sure what the equivalent would be here, but it is not a psychiatric institution.

If a family goes in the hospital and the child is left without care, a foster—a state institutional home for kids. The family was evaluated by that service and the kid was felt to be not in need of shelter services. In that case, the mother came to our clinic, simply saying she would like her kid put in a psychiatric hospital because she is tired and she can't take care of him. We got her some help.

We did not hospitalize the kid, not to punish him, just because she could not take care of him and she was labeling the kid as emotionally disturbed to get him out of the home.

It was for his benefit, really, she couldn't take care of him, but we did give her support with a homemaker and visiting nurse coming in and rallying her family around her.

So the kid did not have to be put in a (98) state institution.

Q. The best interest of the child in that situation was served, was it not?

A. Yes, without institutionalization, even though that is what was originally requested and we were able to resolve it.

Q. And the parent sought help from your clinic?

A. Yes, and we didn't need the hearing.

Q. What would happen in your opinion, Doctor, if a hearing were provided and the juvenile had an attorney and the attorney looks at all the facts and he decided to capitulate and decides that it really would not be in the best interest of his client to have a hearing; that he is convinced?

A. It would be in the best interest of his—

Q. "I have reviewed all the facts and evaluations of the psychiatrist who my client has had"—is not too certain whether he should go to a hearing. What would you do in that situation?

MR. FERLEGER: That is not within his competence if an attorney decides to waive a hearing, if the Court grants attorneys to waive such a hearing.

JUDGE GIBBONS: Sustained.

Q. Would you define what you know to be an emergency situation as versus a non-emergency situation?

(99) A. An emergency situation is one where a patient is imminently dangerous to himself or others as a result of mental illness, whatever that is.

Q. And a non-emergency situation?

A. Is one in which that is not the case; in which those criteria are not fulfilled.

Q. Could the modality of treatment still be essential for a non-emergency patient as immediate as for one who is, say, dangerous to himself or others?

A. You will have to say it again. I'm sorry.

Q. For example, could a person who is a non-emergency commitment require help as quickly as one who is a candidate for an emergency situation?

A. As I undestand your question, you are asking, is a non-emergency situation equally an emergency as an emergency situation?

Q. In essence, yes, in terms of treatment or hospitalization.

A. The answer is no.

Q. Let me ask you this:

Can a patient—can a prospective applicant, because he has to go through a judicial process, be delayed to such a length of time that what was a non-emergency situation becomes an emergency situation, where no one becomes fully aware of it?

(100) A. Patients die with their rights on and with their rights off. Patients die who are in treatment and patients die who are out of treatment.

We psychiatrists as a class, are pretty good at formulating diagnoses. We are pretty good about dealing with people about how they feel; we are pretty good in listening to them. We are bad in predicting what they are going to do. People suicide and kill others who are in psychiatric treatment. That is despite efforts of psychiatric treatment.

To lock people in psychiatric hospitals on the vague prediction they may do harm to themselves in some uncertain way or some uncertain time is a severe abridgement of their civil rights.

Q. Is it your opinion that a hearing should be provided only for the juvenile who objects, or for any person, you know, 18 years of age and younger?

A. Only to the juvenile who objects.

Q. So, in other words, if you have a juvenile who cannot even formulate an idea, who is so removed, if you will, then you feel it would be in his best interests to allow the parent to admit him, notwithstanding the fact that he has not objected?

A. If the child is unable to object?

Q. He is unable to object.

(101) I am sure you have seen—well, I'm sorry.

He is unable to object.

A. Well, at what age?

Q. Let us say, it is irrespective of the age. As long as he is in the age group.

A. Are you implying the child is unable to object because of some emotional or mental impairment?

Q. As you may know, the statute addresses itself to not only mentally disabled, but mentally retarded.

A. Yes.

Q. So if you have a severe mentally retarded person—

A. If you have someone who is that severely mentally affected that he can't speak for himself when asked if he wants an attorney or what his rights are, if he can't respond to that at all, I think chances are, he requires inpatient treatment, if someone else thinks he does on the outside.

Q. What about a person that is so out of touch with reality, that one of their behavior modes is objecting to everything? That their objection is really not an objection as you or I would know it, but it is just a form of their behavior pattern; do you feel that a hearing should be provided in that instance?

A. I can't picture the kind of person that you are talking about. Someone who objects; when you say yes, (102) he says no?

Q. Yes.

A. Someone who is just obstinate?

Q. Correct.

A. Well, I don't think that is a ground to commit someone to a hospital.

Q. I am not saying that is the grounds.

I am saying that is one of the elements of his behavior and assuming other conditions of his behavior warrant admission into a hospital, do you feel in that situation the person ought to be afforded a hearing?

A. Yes.

Q. Why?

A. Because he is a human being who has rights and if he objects to being hospitalized and he is not in danger of harming himself and others imminently, that he has a right not to be locked up in a hospital.

Q. So, it is your feeling and opinion that a hearing should be provided to anyone prior to their admission into a facility where they object to that admission; is that correct? Notwithstanding the fact that to object may be valid or invalid.

A. That anyone who does not want to be hospitalized on a non-emergency situation, we are talking about?

(103) Q. Yes.

A. That if someone does not want to be hospitalized, sure, I think he should have a hearing.

JUDGE GIBBONS: Regardless of age?

THE WITNESS: Regardless of age.

Q. Are hearings provided in Rhode Island?

A. Under the current mental health law, after hospitalization, but not before.

JUDGE GIBBONS: Does Rhode Island have any provision for juveniles voluntarily admitting themselves without parental involvement?

THE WITNESS: I don't know.

In our clinic we will see juveniles without parental consent and most of the time we will try to get parental involvement, if only for consent later.

Q. Does your clinic provide in-patient treatment?

A. No, we do not.

Q. Have you ever been associated with a state institution?

A. I have not directly worked for a state institution, but I am currently associated with the state institutions in that I teach there and have rather extensive liaison with them, because that hospital has a large course of referrals to my clinic, which is a public clinic. So I am quite familiar with the situation in an in-patient (104) state hospital facility.

Q. There's been some discussion with the prior witness about juveniles calling for help; do you think there's anything to the fact that a juvenile is often objecting because he is seeking help?

A. I don't think a juvenile objecting to hospitalization is a plea to help. It is possible you might interpret that behavior that brought the child to a hospital, psychiatrist or a hearing, like stealing or using dope; you might interpret that, if you wish, as a plea for help, but refusal. I don't see as a plea for help, no.

Q. So, that it is true that the key to diagnosis would be not the subjective symptoms which the patient reports, but the acting-up behavior?

A. That can be viewed as a symptom.

Q. Aren't juveniles reluctant to provide that behavior?

A. They do that with a great deal of zeal, from my experience and they are less happy to report they are depressed.

MR. ROTH: If it pleases the Court I would like Mr. Moss who is associated with me to continue with some questions.

JUDGE GIBBONS: All right, proceed, Mr. Moss.

Continued Cross-Examination

BY MR. MOSS:

(105) Q. Dr. Ingall, you stated in your direct examination by Mr. Ferleger that you were opposed to hospitalization and institutionalization because you feel other alternatives are not explored and you feel for that reason the child should have a prior hearing, because he cannot convince the medical people treating him that he should be treated in some other alternative.

Do you have any evidence that indicates that other avenues or other alternatives are not explored by the medical people treating the child?

A. I know of circumstances in which people have been referred for hospitalization by virtue of the fact that the doctor whom they saw was too busy to make a complete evaluation of the situation and felt that it would be

easier to admit the child to an in-patient facility, where other staff, besides himself would be able to do this.

Q. You know that through a personal experience?

A. Yes, I do.

Q. Do you feel that having a prior hearing is the only route to making these other alternatives?

A. I think more community alternatives need to be made available. I don't think the hearing is the end all. No.

Q. Cannot this function and isn't this function done by the other social agencies involved with the child and isn't it true that other alternatives are explored?

(106) A. Explored?

Q. Yes.

A. Often that is the case.

Q. You stated that—

A. I think we are talking here about the exception, rather than the rule. I don't see every kid for whom hospitalization is proposed as coming before a hearing.

Q. You stated that there is no trauma from a prior hearing because there is already a disruption in the family patterns.

Is that an assumption on your part and do you have any figures which would show the percentage of children admitted from homes where the family has been disrupted?

A. You mean do I have proof that a hearing is not—

Q. Have you read any studies or have you done any studies of your own which would indicate that in most situations, the family has been—the family patterns have been disrupted?

A. Yes, I have read studies—they have been disrupted by hospitalization or beforehand.

Q. You stated that there is no trauma which develops from a prior hearing, because the family patterns have already been disrupted, right, which is an assumption, if I understand your response, is an assumption on your (107) part, then, that in all situations in which an adolescent is in need of hospitalization or reaches the point that he is in need of acute psychiatric care, that the family pattern has been disrupted; that there is a break in the family pattern.

Do you have any knowledge as to any studies having been done or any figures which support this?

A. Figures—I am sorry, you mean that kids who are in hospitals come from families where there is emotional disturbance among the family?

Q. That the family pattern has been disrupted, to use your term.

A. Has been disruptive?

MR. FERLEGER: Disrupted.

A. I know from personal experience and textbooks and articles that I have read, there is a good deal of evidence to show that kids who are in psychiatric hospitals come from families where there has been familial disruption.

Q. You don't know whether there's been disruption which has taken place prior to hospitalization?

A. Yes, prior to hospitalization.

Q. Prior to the hospitalization?

A. Yes.

Q. You stated that sometimes, by the time the hearing would come around, it would not be needed.

(108) What percentages of these cases have you seen?

A. We don't have a hearing system where I work prior to hospitalizations, so I can't tell you what percentage.

Q. What about the proposed hospitalization hearing situation? You testified to something in regards to the hearing not being needed.

Do you recall what you stated?

A. Yes, I think I said that if there is a delay between the time hospitalization is proposed and a hearing takes place, that it may be if that interim between the proposal and the hearing when a decision will be made, that the hearing—that family communication is enhanced to the point that they can resolve that hospitalization is not needed and that alternative treatment can be used or alternatively the situation may deteriorate where all involved feel that hospitalization—either the child agrees that hospitalization is needed or else the situation reaches emergency proportions, in which case emergency commitment can be applied.

Q. In a situation where the hearing is not needed and actually what has taken place is that the wounds of the illness have healed themselves through time.

A. I wouldn't go to that extent. I think if you have reached that kind of situation, things are not going to be (109) better forever after, simply because hospitalization is going to be avoided.

Alternative treatment is often very useful.

Q. You were asked on direct examination, that if a proposed commitment hearing were held, would it be harmful to the child and you stated, you feel that it is better to have a hearing before.

I would like to ask you that question again and respecting your desires of wanting the hearing prior to commitment, can you tell me whether you feel in your professional opinion whether a proposed commitment hearing would have any harmful effects?

A. No, I can't see that it would.

Q. You did state it would not hinder the treatment process if the child is represented by Counsel prior to the commitment; that it would not hinder the relationship between parent and child.

Can you tell me why?

A. I can't see any way in which it would hinder it. You are implying that it would.

Q. I am just asking you for your opinion and you stated on direct—

A. I don't think it would be harmful.

Q. You have no reasons why?

A. Yes, it would not be harmful.

(110) Q. As a psychiatrist—

A. It is not harmful for a child to meet with an attorney or guidance counsellor working on his behalf. It can be beneficial.

Why should it be harmful to meet with a lawyer? They are not so bad people.

Q. You are a therapist and in private practice and treating a child and it reaches the stage where you feel the child needs to be hospitalized and the child does not accept your suggestion, you then take the next steps to have him hospitalized and the jurisdiction that you happen to be in there is a statute that says that there must be a prior hearing.

The only person who has worked with the child and who is aware of the child's illness is you, the therapist, and you are the only person who can testify to the Court what is wrong with the child and why he has to be institutionalized.

The child is in the courtroom and you are there testifying. Are you not becoming an adversary to the child?

A. In a sense, yes, you are right.

In a sense, that might be disruptive to our treatment relationship. However, more disruptive would it be if I didn't have a lawyer representing that (111) child and I, myself, by picking up a pen, signed a paper and said, "Too bad, you are going whether you want to or not," and it was all on me.

That would be much more disruptive.

MR. MOSS: I have no further question.

MR. ROTH: No further question.

MR. FERLEGER: No further question, your Honor.

JUDGE GIBBONS: Thank you, Doctor.

We will recess until two o'clock.

(Whereupon, at 1:00 o'clock p.m., a recess was taken.)

Afternoon Session

(Whereupon, at 2:00 o'clock, p.m. all Counsel and parties being present, the following transpired in open Court.)

MR. FERLEGER: Your Honors, at the end of Dr. Ingall's testimony, I neglected to move for the admission of his Curriculum Vitae.

JUDGE GIBBONS: It is admitted.

JUDGE HUYETT: Which Exhibit is that?

MR. FERLEGER: Number 6.

(Whereupon, the Curriculum Vitae of Dr. Michael A. Ingall was marked plaintiffs' Exhibit 6 in evidence as of this date.)

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(112) ELI CHARLES MESSINGER, Sworn.

THE CLERK: Would you state your full name?

THE WITNESS: Eli Charles Messinger.

Direct Examination

BY MR. FERLEGER:

Q. Doctor, what is your occupation?

A. I am a psychiatrist, a child and general psychiatrist.

Q. What is your present affiliation or appointment?

A. I am assistant attending at St. Luke's Hospital Center, New York City.

I am a clinical instructor in psychiatry at Columbia Medical School College of Physicians and Surgeons and I am currently employed at the Neighborhood Health Service program.

This is a federally funded comprehensive health care program in Manhattan. It has a mental health unit of which I am acting psychiatric director.

I also have a small private practice and work with both children and adults.

Q. What has been just generally your experience in terms of years and type of treatment in child psychiatry?

A. I am a trained child psychiatrist. I had two years of child psychiatry fellowship at Bronx Municipal Hospital Center in the early 1960's.

(113) The two years were separated by two years in the Public Health Service in which I served as psychiatrist and chief medical officer at a federal reformatory in Oklahoma.

There, I worked with youthful offenders.

I have been in the practice of child psychiatry since 1965 and all my salaried positions have been in this area.

Q. Dr. Messinger, are you certified by the American Board of Psychiatry and Neurology?

A. Yes.

Q. When did that certification occur?

A. In 1966.

Q. And are you also certified in child psychiatry?

A. Yes, in 1970.

MR. FERLEGER: Any question, Mr. Roth, as to qualifications?

MR. ROTH: No question.

Continued Direct Examination

BY MR. FERLEGER:

Q. Dr. Messinger, one brief thing with regard to your qualifications, have you given any talks or written

any papers with regard to the relationship between law or legal rights and psychiatry?

A. Yes, I have.

I have delivered a talk to the American (114) Orthopsychiatric Association on some interconnections between the legal and psychiatric systems.

I have written an article for the Journal of Medical Probation on the psychiatric treatment of the youthful offender.

Q. Doctor, can you describe to the Court what age children you have treated and what institutional or non-institutional contacts you have had?

A. My experience with in-patient psychiatric work with adolescents and younger children was confined to the years 1960 through '65, with the two years in the Public Health Service and there, I worked with children of all ages, down to at times, three or four, who had to be hospitalized and with adolescents who were in the hospital, too.

Since that time, I have treated children and adolescents of all ages, but not in an in-patient setting.

Q. Does your facility which you are presently psychiatric director for, ever refer children to in-patient settings?

A. Yes, but very rarely.

Q. Dr. Messinger, can you please describe the current orientation in child psychiatry regarding the role of the family and the family structure and the difficulties (115) that children may have?

A. Yes, I believe that there is wide-spread agreement in the field of psychiatry, as well as the other mental health professions, social work and psychology, that the

problems of children and the problems of their parents are inextricably connected; that the family should be viewed in many instances as the locus of pathology or trouble; that it is impossible to understand the symptoms and behavior of any one member of the family without understanding its role in the family in maintaining the family equilibrium; that symptoms are often an expression, be it a distorted expression—a distorted attempt to communicate, make demands on, ask help from, seek the support of other members of the family.

I think that it is unwise to think in terms of blame of either the parents or the children, but that it is wise and necessary to view the interrelations between the problems of the designated parent—designated patient, excuse me. Certainly, if that patient is a child or adolescent, to see those problems in terms of the whole family structure.

Q. Does it occur, Dr. Messinger, in families which present a child for psychiatric treatment that the families or parents, for example, in families might also be in need of psychiatric care?

(116) A. Very often, that is the case and this is not a current fad in psychiatric thinking.

It really goes back a full half century to the beginnings of the child guidance movement which had its origins in psychiatry primarily and here in Philadelphia, and this was recognized in the very structure of the child guidance clinics which were organized so that the psychiatrist—usually a psychiatrist who worked with a disturbed child, had as an ally in therapy the social worker who did counseling or case work with the parents.

Q. Dr. Messinger, in terms of this family orientation of psychiatry, do you have any opinion as to whether

or not an institution, such as a state mental hospital or a similar facility would be more or less likely to involve the family than a community facility?

A. In my experience, it is inevitable, that an institutional setting pays less attention to family pathology and family dynamics, than does a community facility.

Q. Why would that be?

A. I think that there are a number of reasons, starting from the most obvious. Many of them are physically separate from where the family resides and perhaps, at best, the family can afford to take a bus trip or a train trip to a facility in the countryside maybe once a week (117) or once a month.

Sometimes, the treating psychiatrist or social worker isn't there on the day that the parent who is taking time off from work, for example, or coming on a weekend. The treating psychiatrist, he isn't there to have an interview with that person, but there are other considerations which are less tangible and that has to do with orientation and I think the orientation of institutions tends to be that the designated patient is the sick one, that the pathology resides within that individual and they tend to overlook, or at least under-emphasize the ways that those problems—under-emphasize the interplay between the designated patient's difficulties and those of the rest of the family.

I might add that this family orientation to psychological difficulties has been one of the major trends in the last 10 or 20 years.

Again, Philadelphia happens to be a center of research and treatment in this area and the modality of treatment which has emerged from this orientation is called conjoint family therapy. That is, all members of the family

are involved, usually with the same therapist and in the same room at the same time in working out their problems

Q. Is that because the family is seen as needing help (118) as a whole or is the family just there to help with the child's problems?

A. Both. I mean, even if you have a disturbed youngster who has a disturbance onto himself, so to speak, the family does need assistance in its coping with that. Almost inevitably.

Q. Dr. Messinger, in the light of this situation, do you feel that parents are always in a position to judge what is best for their children in terms of psychiatric care?

A. I think that when a parent or when parents knock on the door of a social agency or a psychiatric facility and say in effect, "Do something," whether the "do something" is give medication, put him in the hospital, do some tests, they are saying that the problem is serious enough so that they can no longer cope with it; that whatever their internal resources, the stress and strain is beyond them.

That is, I think, a role that parents should take. I think that is a very different question from what is the best kind of treatment approach once one has identified that either a child or adolescent or a family is in trouble.

Q. Dr. Messinger, could you describe in terms of its effect and its nature the differences between institutional (119) treatment of psychiatric problems as opposed to community facilities?

In other words, why might there be a desire or a belief on your part as a psychiatrist that institutional care might merit different procedures than non-institutional care?

A. Let me try to answer that first by citing the advantages to a practicing child psychiatrist of working in a community facility and obviously in my own professional work, that is where I have chosen to be and then, to talk about some of the disadvantages or even dangers of institutionalization.

The advantages of working in a community facility are that one can readily be in touch with the child's family, with the child's school, with interested relatives or friends, with a variety of community leaders or helpers.

For example, a counsellor in an after-school recreation center. Even a store-keeper who has a friendly relationship with a teenager who most other people can't stomach, but one has access to what we call in psychiatry, "the social support system," and can bring our weight to bear on strengthening that social support system.

In practical terms, the institution that (120) usually blows the whistle on trouble for a child is the school, because of truancy, academic failure, misbehavior in the school.

If one works in a community facility and sees the child there, then one can—and I do these things—go to the school and talk with the classroom teacher, talk with the guidance counsellor and principal and if necessary make arrangements for transfer to another classroom, transfer to another school or transfer to a specialized school that will handle a youngster with whatever problems they might turn out to have.

Some other advantages—well, let me go to some of the disadvantages of institutionalization.

One is rooting the child out of the family and community, starting with the situation of excluding the child

from the family. I am not saying that that is never necessary. In extreme cases, it is. However, because the child's symptoms are immersed with the problems of the family, if there are going to be real changes in that child, there have to be concomitant changes in the family.

If the child remains at home for treatment, then one can work with both sides of the equation together. If a child goes to a state hospital, for example, for three months and then returns considerably improved, the (121) likelihood is that because of unresolved difficulties with the family, there will be a reoccurence of those problems. In terms of being uprooted from the community, it means at least that the adolescent who returned three months—I use the figure three months as a rough average for how long adolescents spend in hospitals—the child will return in three months time to his or her neighborhood school and there will be very difficult problems in readjustment, the embarrassment of meeting peers who ask, "Hi, Joe, where were you?" What is Joe to answer—"Well, I was in the State Hospital."?

It is a difficult situation to impose on the child. There is at least temporary loss of the social support system that I spoke about earlier.

Now, in terms of the dangers and drawbacks of institutionalization per se, I feel on very firm grounds, because I think that the entire field of psychiatry has been sensitized to the dangers certainly of long term institutionalization. In a sense, the derailment from the usual course of one's life, the dreary regimen even in the most progressive hospitals, the extreme deprivation and limits, including simply going where one wants to, dressing as one wishes, corresponding or communicating with friends, relatives, et cetera.

These are extremes. Then, too, the term, (122) "stigma" has been mentioned several times. I'd like to spell that out in somewhat greater detail.

I think there is a social stigma and I think there is a self-stigmatization that occurs, too. From a social and legal point of view, it means that that person, every time he fills out an application for college, the military, driver's license, hack license, et cetera, employment, is obligated in most states or at least in many states to state, "I have been a mental patient," and that is certainly going to give the school or the potential employer cause. While attitudes have changed slightly for the better in terms of some greater acceptance of the phenomenon of mental illness, they have changed very, very slowly and I don't know that we can predict in 1974 how employer "A", "B", or "C" is going to react to the fact that someone who asks for employment has been in a mental hospital.

Lastly, the fact of being in a mental hospital has profound repercussions in terms of that person's self-image and self-confidence. No matter how much they might wish to dismiss it as even an unfair event—and maybe it was—or "I got into the hospital only because my Aunt Tilly couldn't stand me"—it shakes a person's self-confidence to the core and I speak from experience in dealing with many patients who have been (123) through hospitals.

When they have been designated a mental patient, because no matter how scientifically and how manly we look at that phenomenon, there are traces of much older superstitions about it and we really do distrust the judgment of those who have been labeled "mentally ill".

Q. Dr. Messinger, as a result of the analysis of institutionalization, do you have any opinion as to whether

or not there ought to be a prior hearing in the non-emergency situation of a juvenile for commitment to a mental hospital?

A. I think there definitely should and I think that there should be in every case.

Q. Can you explain, if you will, the reasons that you believe that children ought to have a hearing?

A. There are many.

One is to sort out the facts. One of the prior witnesses said that lawyers are better trained to ascertain matters of fact than psychiatrists. I think that is true. I think we emphasize different kinds of data, but certainly, there should be the most careful gathering and weighing and discrimination of the facts of the situation. That is especially pertinent, because feelings tend to run high in such matters. One does not (124) have such a serious breach in family integrity, in family unity, without feelings running high and what happens most often is that there is a decided difference of opinion between the parental generation and the child or adolescent, as to what is going on and what the implications of this are.

For example, when Mary, age 16, asks to go to the school dance Friday night, that might mean to her, "I wish to meet some new people. I want to have some fun. There is someone there who I'm looking forward to seeing."

To parents, from their perspective it might mean, "She is out of control. We have prohibited her from going out; she should do her homework instead. What is going to come of her if we allow her this next freedom?"

What I am saying is from each parent's point of view, there is a very different assessment of the facts.

Q. Could you experience situations where the family misperceived or misinterpreted facts, which, if true, would have meant involuntary treatment for the child, but if not true would have meant no treatment for the child?

A. It usually does not hinge on a single matter of (125) fact. I think it hinges on a consistency type of coloring of the facts and what one sees as relevant in another person's life and from that point of view, yes.

Q. Parents do select things out that might in a way color the facts that are presented to the psychiatrist.

A. That happens almost inevitably.

Q. Dr. Messinger, could you please describe, if you can, what benefits, almost in a therapeutic sense, a hearing might have for a child, a prior hearing?

A. I think the major one is that a child wants to be treated fairly and that a judicial hearing is just that kind of impartial way of the facts and objective decisions as to what is best done about them.

Q. What effect would that have on the treatment that might occur if the child was ordered to have treatment?

A. I would agree with I think it was—well, both the prior witnesses, that that frees up the treating psychiatrist whether in an institution or outside of it, to do the treatment, help the person sort out their feelings and thinking about their life experiences.

If I am in the dual position of incarcerating a youth and also of asking him, "How do you feel about being incarcerated," I am in an untenable position. That has been recognized in settings where administrative decisions are separated out from psychotherapeutic (126) responsibilities.

So one psychiatrist wears the hat of administrator and another as therapist and I can't imagine that there would be any harm in the facts as they are being laid out before the child.

In fact, I think that it would give him pause and might lead him or her to reassess their opinion.

Q. With regard to the possible delay prior to a hearing in an non-emergency situation, do you feel that that delay would mean in your opinion that there should not be a hearing or what do you mean would be the advantages or disadvantages in such a delay?

A. I don't see any disadvantages.

I think in fact that the situation is somewhat safer with children who will either be living at home and thereafter are under some scrutiny—

Q. Safer than with whom?

A. Safer than with adults.

This is the situation with adults in the state of Pennsylvania. If the danger considered is, what if the situation becomes deteriorated and becomes more dangerous?

I think we are on safer grounds with children, because they are under the scrutiny of the parents or if they are in a foster home, the foster parents and (127) usually the school, too. If the situation deteriorates badly, then there could be a reconsideration as to whether it has become an emergency situation, but I would underscore the statements of both the prior witnesses that there are major and dramatic shifts in the behavior of adolescents. If there is anything that characterizes the behavior of adolescents it is that they are changeable and that very bad situations can right themselves.

There is another factor here and that is, once a family comes to psychiatric or a social agency's attention, efforts can be made to help the parents better cope with the situation. That, in and of itself, might give the adolescent another opportunity to regain their psychological equilibrium.

Q. Dr. Messinger, I would like to ask for your opinion and comments on some of the facts that have been agreed to in this case with regard to one of the named plaintiffs in this lawsuit.

MR. FERLEGER: Just for the Court's reference and Mr. Roth's reference, paragraph 21 of the final prehearing order with regard to Leslie Levine. Levine's parents are divorced. Her father's remarried and living in family. She would have at the time of her commitment, at the time this action was filed, liked to have been with her father because she gets along well with him.

(128) Every time she visits with her father her behavior is excellent. Levine's difficulties in relating to her mother resulted in her commitment.

Hospital records indicate that Levine threatened the lives of her mother and sister and that she has "a personality disorder".

Q. I wonder if you can comment as to whether or not this is typical, that an adolescent's behavior might change so dramatically with the environment, here with the father she acts one way and with the mother she acts another way.

A. The answer is, yes, that that is typical. It is typical of adolescents and it is typical to some extent with all people, that who we are is a function of the social setting.

By the way, I think that that has relevance to the question of procedures to be undertaken before hospitalization, that if an adolescent is brought to a psychiatrist, let's say, in the admitting room of a hospital or even to a psychiatrist in a community clinic, such as my own, but knowing that the parents wish to commit that adolescent, that the social context will have much influence how the adolescent behaves.

For example, the adolescent might say to himself or herself, "I'm up against the wall. Mother (129) and Dad want to send me off to the State Hospital and here's the strange psychiatrist who I have never met—" and God knows what their fancies are about psychiatrists in general— "I better not open my mouth for fear it will make matters worse," or they simply will say, "This isn't fair and they are against me," and it sounds paranoid.

If that child was able to see someone who they knew was their advocate in a different setting, they might present a lot more information and a lot different sounding information than in, you know, the other settings.

To return to the example, though, I think that that example demonstrates that there are legitimate differences of opinion and interest within a family. Sometimes, as in that family, it is between two parents and the child happened to side with one, versus the other. One would have to ask why does she have the personality disturbance when living in Pennsylvania, but the disappearance in Florida. Oftentimes, though, the conflict of interests is between the parent generation and the adolescent, because they have very different attitudes, experiences and values. The question is not who is right, but the question is that this is a very real and sometimes extremely intense kind of conflict between the two generations.

(130) Unfortunately, and I think that this is very dangerous, the parents can sometimes utilize psychiatric authority to deal with the issue and the psychiatric authority can either say, "Yes, you are right, long hair and smoking marijuana is evidence of mental illness," and might go another step further and say, "This is a dangerous situation; the child ought to be in a psychiatric hospital."

We have to remember that in psychiatry, except for neurological diseases, we are dealing with behavior and the behavior that we are most concerned with is social behavior. That is how an individual influences or affects another.

Most often, the social system that we are concerned about is the family. It is—hospitalization is rarely done because of mental illness, per se. It is done because that person's behavior, whether you want to call it mental illness or not, in a way is beside the point, adversely affects, disrupts, angers, upsets, challenges, the interests and attitudes of the people that they impinge on.

Q. With regard to the regulations of the state as adopted, which involve an evaluation at a base service unit of one facility in Pennsylvania and then an evaluation at a state hospital, the facilities where the person is to be committed, do you see any difficulties with those (131) sorts of procedures?

A. Yes, I do.

Q. What are they?

A. For one, some of the concerns that I have had about, for example, the adolescent having the setting and whether the adolescent feels that this is the place where he can open up an share his true feelings as to what happened, I think that might be as true in a community facility as in a state hospital admitting room.

I know that from my own experience in a community clinic, it often takes months to really get to know a child, for them to open up and for me to gather data from the family, school and child that will give me a rounded and balanced view of the situation.

Q. So, you think that the evaluation that those regulations require might not really get the information needed to make a recommendation?

A. That's correct. The data we are dealing with is not hard scientific information.

You can't read a meter and the dial rests at one place or another. You need to gather information, sometimes the most personal, intimate and disturbing kind, about not only one individual, but a group of individuals, and not only about that one family, but their relationship to the community and school in which (132) they live. This is a painstaking and complete process. That was one of the reasons that I think a hearing would be in order. It slows down the momentum.

Q. Now, Dr. Messinger, do you see any difficulties with the state hospital confirming the recommendation of the referring psychiatrist?

A. I do, because psychiatrists are people, too, and we are influenced by considerations other than those that are strictly clinical.

For example, if I, as director of a state hospital get a letter from a colleague in a community facility, saying that John Doe really needs psychiatric hospitalization and is serverely disturbed, even if I felt otherwise from a direct discussion with the patient, I would be in an awkward position if I said, "No, this patient does not require hospitalization."

What do I then say to my colleague whose opinion I disagreed with?

Secondly, professionals—psychiatrists who work for institutions, are influenced by the needs of the institution, as well as the needs of the individual patient.

If I am the director of an adolescent service and the funding of my unit depends on how fully utilized the unit is, I might be on the side of admitting (133) the adolescent. I am not saying this is done deliberately, but I think that a decision as complex as hospitalization is influenced by factors within the psychiatrists at a number of different levels and such considerations as bed utilization will play some role.

Thirdly—

Q. Doctor—

A. There is another consideration.

Most of the data that we use in making a clinical assessment of a child, comes from the parents. We usually do not depend all that much on the child or adolescent giving us a full, detailed view of their life, so that the information that largely influences the first psychiatrist's decision will be the information that largely influences the second psychiatrist's decision.

From that point of view, I think it is—necessary to bring in—it is preferable to bring in someone from a different discipline, namely a lawyer, and working in a very different kind of setting.

Q. Now, Dr. Messinger, do you see any reason why there shouldn't be a hearing for younger children who might not object in their commitment?

A. I think in fact that the need for a hearing in the younger children is greater, because one cannot expect them to understand fully, certainly in legal terms, their (134) dilemma, nor can they be aware of alternate forms of therapy.

Now, obviously, the form of such a hearing and how the child is to participate in it will be a matter for, I think, very delicate—very delicate concern. I think that most any child can have some meaningful input into a discussion of his or her future.

The input from a five year old will be very different from a nine, thirteen and eighteen year old. One cannot ask—one has to speak the language of the child and listen to the language of the child, but I think that because younger children are less sophisticated and less knowledgeable, that we have to bend over backwards to protect their rights.

Q. Now, Dr. Messinger, do you see any difficulties with the state's provision of a hearing after commitment, especially for a child who might after a hearing, be found not to have been in need of commitment in the first place?

A. I think it is a most inadequate provision and it is closing the barn door after the horse is out. I think it is disastrous to hospitalize a child and then find out, by golly, it wasn't necessary. That is playing with a child's life.

Q. Dr. Messinger, the regulations also provide that (135) once the child between 13 and 18 is placed in an institution, that the child may then raise an objection after being read a notice that he or she may do so. Do you have any opinion with regard to the validity or the possibility of objections being raised at that point?

A. I don't understand the question.

Q. Once the child gets read the notice of his or her rights, that they may object and then obtain a hearing, do you see any difficulty with the validity of the possibility of the child raising that objection once the child has already been in the institution?

A. Possibly—let me think this out.

One is that the child is then in some wise at the mercy of his keepers and might tend to simply accede to their point of view.

Secondly, there is a kind of indoctrination and I am not using the word in that sense exactly, but there is a kind of indoctrination that occurs whenever a person is in an institution. The kind of indoctrination that we psychiatrists do is to say to somebody in a mental hospital, "You are ill. You have personality difficulties within you. You need treatment." And almost universally it is said, "The treatment that you need is the treatment that we are providing."

So, this I think also would make it more (136) difficult for the adolescent to say, "No, wait, I see things entirely differently."

Q. Dr. Messinger, just to finish up a few miscellaneous points, is it your opinion that adolescents can or cannot apply for admission to facilities on their own or ought they to have the parents' consent or advocation?

A. That is a delicate question.

I would like to see adolescents be able to obtain psychiatric treatment as out-patients and even as in-patients, because they felt it was necessary, if indeed the psychiatrist agreed—

Q. Of course.

A. —because there are instances that the adolescent is troubled and knows it and the parents have a need to deny it.

I am not in favor of doing this behind the parents' back. You know, I am a parent myself and I want to know what is happening with my children. I know that there is a trend towards giving adolescents greater discretion about seeking medical treatment on their own and I would hope that that would be extended to psychiatry.

In fact, that is done; it is done.

Q. Dr. Messinger, what is your opinion with regard to whether or not the involvement of a lawyer as Counsel for a child would interfere with the ability of the child (137) psychiatrist such as yourself to deliver needed services to juveniles?

A. Could you be more specific as to how it would interfere, because offhand, I don't see how.

Q. I am asking you whether or not you feel it would interfere?

A. I see no reason to think so.

MR. FERLEGER: No further questions at this time.

Cross-Examination

BY MR. ROTH:

Q. Dr. Messinger, I will just ask you a few questions.

Are you opposed to institutionalization?

A. I think that hospitalization or institutionalization for example, in a facility for mental defectives, should be

a last resort and that as much work as possible, as much effort as possible should go into finding some other resolution of the child's and family's difficulties.

I have recommended hospitalization for children and adolescents when I thought that all other remedies had been used.

Q. Then, is it my understanding that you feel that institutional treatment is a good treatment program, if the institution is rendering good treatment and the child needs institutional treatment; you have no problem (138) with that concept, then?

A. Correct.

Q. Didn't you, in fact, write an article, "A Psychiatrist's Views of Institutional Treatment of Young Adult Offenders," in 1965?

A. I wrote the article.

Q. Doctor, you have testified about stigma. Let me ask you, to avoid stigma, would you not hospitalize one in need of such?

A. It is like so many of these questions, a matter of judgment and in weighing whether someone should be in the hospital or not, I would consider, and particularly for a younger person, what effect will this have on his later life, because a move done at a certain point in that person's life, while it seems judicious then, might later turn out to have harmed him and there are examples of a person who entered the hospital sometimes on their own for a two month period and then wanted to go to medical school five years later and was denied admission.

I guess one can argue one way or the other as to whether that initial psychiatric hospitalization was in the overall long term best interests of that person or not. I

am just saying that we have to be cognizant of the enormous social toll that institutionalization brings.

(139) Q. Fine, I appreciate that answer.

The question still remains, Doctor, to avoid stigma, would you not hospitalize one who is in need of hospitalizaion, who requires that and that's the only form of treatment that can be given, because other treatments have been explored, but they are not acceptable for treating the person at that particular level?

MR. FERLEGER: Objection. He has just answered that question.

JUDGE GIBBONS: No, he did not.

Overruled.

A. If the person requires to be in the hospital, then, they require to be in the hospital and I would assist in that.

Q. But the question remains, to avoid stigma—

JUDGE GIBBONS: He has answered that question now. Pass on to something else.

Q. With regard to patient Leslie Levine, whom you addressed yourself to, are you aware of the personality disorder of Leslie Levine?

A. I know no more about Leslie Levine than what the Counsel read.

Q. Now, you have testified that institutional psychiatrists do not become involved with family orientation.

Is that true in Pennsylvania? Are you (140) aware of that in Pennsyvania?

A. As a rule, and I have not spoken to psychiatrists who work in Pennsylvania state hospitals, as a rule, psy-

chiatrists who choose to work in institutions do not have a strong commitment to a family outlook on psychiatric problems.

Q. Do you have any statistics to buttress that statement, any articles?

A. In a negative sense, yes.

I know that those who worked in such institutions do not write articles about the family aspects of psychiatric problems.

MR. ROTH: Your Honors, I have no further questions.

JUDGE GIBBONS: Dr. Messinger, you spoke about the possible therapeutic benefits of a hearing, precommitment hearings for the child, because the child wants to be treated fairly.

Is there any empirical data as to how children perceive the judicial process?

THE WITNESS: I don't know any.

JUDGE GIBBONS: In the absence of such data, how is it possible to say that the child will receive a therapeutic benefit from a perception of being treated (141) fairly, if in fact, the data suggests that children perceive the judicial process as hostile and unfair.

Would your conclusion of a therapeutic benefit still follow?

THE WITNESS: I am not happy with the term "therapeutic benefit". I believe it should be done, because it should be done, to protect the interests of

THE WITNESS: I would assume so.

JUDGE GIBBONS: Why do you assume so?

THE WITNESS: I might be in error, but I would assume that the authority of the Court might be such that they might, for example, obtain information about the family, that the family would not voluntarily impart.

For example, if parents have committed another child or have been accused or tried for child neglect or have criminal records or the like.

I might be wrong about this, but I assumed that the Court would have authority to obtain such information while the psychiatrists, we are only able to hear what the person wishes to say.

JUDGE BRODERICK: Doctor, I just wanted to clarify one thing.

Other than what we have been referring to (143) as the "emergency situation," are there any cases where you recognize, in connection with the treatment of juveniles, that the in-patient care is preferable to the out-patient care?

THE WITNESS: Yes.

JUDGE BRODERICK: What would one of those be, for instance?

THE WITNESS: It came up recently with a 14 year old boy who I had been seeing on and off in the clinic for the last four months or so.

It so happens that his hospitalization occurred during a time when I was on vacation and the police

the child. I believe that if it is explained properly to the child, they could understand that the judge is a person who will try to find out what is the matter and what is best to be done and that that judge is not—is a different kind of adult than a parent.

JUDGE GIBBONS: Is the process of explaining, with respect to the judge's role, any different than the process of explanation with respect to the psychiatrist's role?

THE WITNESS: I am not sure if—

JUDGE GIBBONS: You spoke of the duality of the role of the psychiatrist.

THE WITNESS: Yes.

JUDGE GIBBONS: Wouldn't the same explanation serve that purpose? That is, serve the purpose of removing from the child's perception the thought that the psychiatrist was somehow his enemy or persecutor?

THE WITNESS: Indeed, I think it is a fact (142) that a psychiatrist who works for an institution does have a dual allegiance and I don't think that the judge who sits on such a case does.

JUDGE GIBBONS: You testified that most of the data that the psychiatrists rely upon under the Pennsylvania dual interview system comes from the parent.

Is it your perception that in a judicial proceeding the Courts would be more able to get information from other sources than the psychiatrists?

had to be called. However, I was considering hospitalization for him and had shared that fact with both him and the parent.

Without going into the details, I think the considerations here were the severity of the pathology, the possible danger of the pathology, how chronic it was and most importantly, how poorly motivated the boy was to obtain treatment.

So, when I and others at the clinic offered him a variety of approaches, medication, sessions, counseling sessions, a summer program, a change in school, he turned his back to all and I had to tell him, "You are forcing the issue and you will have to be hospitalized (144) if you don't make yourself more receptive to things that we might try on an out-patient basis."

As I said, it so happened that he, in a sense, decided that matter in my absence, but I would have hospitalized him.

JUDGE BRODERICK: In his particular case, do you see where there may have been an advantage to have a court hearing to determine his commitment?

THE WITNESS: I think the advantage would have been then, not only I as his psychiatrist, but a separate adult in weighing the evidence came to the same decision and if the judge did not, then I would have to ask myself, you know, in what way did I error and how can I re-examine and revamp my treatment planned, so that it is more effective for this child.

JUDGE BRODERICK: What would you perceive in your view of a judicial hearing for that

young man; what would you imagine would have taken place?

JUDGE HUYETT: Could I add something to that?

What would be the issues of such a judicial hearing? What issues should be decided?

THE WITNESS: I think first of all, an agreement on what are the facts.

Secondly, some assessment of how severe (145) the pathology or disturbance of the child is.

Thirdly, how dangerous the situation is, or might become.

Fourthly, what else has been tried and what else might be tried.

Fifth, what the adolescent himself says about the matter and what he thinks might be best for him, and, sixth, what the family thinks would be best for the boy.

JUDGE BRODERICK: But in that situation, as you would apparently envision that you would testify as to what your opinion is?

THE WITNESS: Yes, I think I would testify as to the facts as I knew them, my experience in working with the boy, something about diagnosis and making a recommendation.

I think the advantage there would be that if the child were then hospitalized, when he came out of the hospital and returned to our clinic, which I think is the only psychiatric facility available in that neighborhood, I would then resume the treatment without my having been in the role of his—the guy who sent him away.

JUDGE BRODERICK: In that situation and I am still talking about the same young man being (146) represented by an attorney at a hearing, would it not be incumbent upon his attorney to perhaps try to find a psychiatrist who would take the position of the child, if he didn't think he should be committed?

A. Yes, I would hope that that would happen, because we are not dealing with black and white matters. We are dealing with very complex—with people who are complex and situations—human situations are very complex and I would want, if there was another professional who took an opposing viewpoint, I would want that viewpoint presented.

JUDGE BRODERICK: Thank you.

MR. FERLEGER: No further question, your Honor.

MR. ROTH: None, your Honor.

(Witness leaves the stand.)

JUDGE GIBBONS: Do you have any further witnesses?

MR. FERLEGER: No further testimony.

With regard to the plaintiffs' Exhibits, I would like to move for the admission of Exhibit No. 1, which are the affidavits of the two juveniles, regarding which Mr. Roth, this morning, was granted ad-

mission of his counter affidavits and I don't believe there is any objection to that.

(147) MR. ROTH: No objection.

JUDGE GIBBONS: Will Counsel take care of marking it afterwards and we will get on with the testimony afterwards.

(Whereupon two affidavits of juveniles were marked plaintiffs' Exhibit No. 1.)

JUDGE GIBBONS: I take it you are offering Dr. Messinger's Curriculum Vitae?

MR. FERLEGER: Yes.

(Whereupon, the Curriculum Vitae of Dr. Messinger was marked plaintiffs' Exhibit 5 in evidence.)

MR. FERLEGER: With regard to two and three, Judge Huyett said we would be able to present them to you—

JUDGE GIBBONS: Does it make any difference whether we rule now?

MR. FERLEGER: No difference. I would be willing to renew this motion at the end of the testimony.

JUDGE GIBBONS: You have made your offer and we will consider that.

MR. FERLEGER: Thank you, your Honor.

JUDGE GIBBONS: Do you have a witness?

MR. FERLEGER: Yes, your Honor, we do.

LEVON DONALD TASHJIAN, sworn.

THE CLERK: Would you state your full name?

THE WITNESS: Levon Donald Tashjian.

(148) *Direct Examination*

BY MR. ROTH:

Q. What is your profession?

A. Medical doctor and psychiatrist.

Q. Are you licensed to practice medicine and psychiatry in the Commonwealth of Pennsylvania?

A. Yes, I am.

Q. Where did you obtain your license, please?

A. I went to medical school at the University of Pennsylvania, interned at Pennsylvania Hospital and obtained my Boards.

Q. Where are you presently employed?

A. Institute of the Pennsylvania Hospital.

Q. Doctor, where did you perform your residency?

A. Jefferson Medical College Hospital and Hospital of the University of Pennsylvania.

Q. What specialities do you pursue?

A. I am Board certified in psychiatry and my specialty is adolescent psychiatry.

Q. How long have you been practicing?

A. For over eight years. That is, eight years following colleges of residency.

Q. What has your role been at the Institute?

A. From 1968 until July of this year, I was associate director of the adolescent treatment center at the (149) Institute, and since July, I have been director of the young adult program and unit at the same hospital.

Q. Are you the recipient of any awards?

A. Yes, I am. I think listed there is the Sol Ginsburg Fellow, for the Group for the Advancement of Psychiatry.

MR. ROTH: Do you have any cross-examination?

MR. FERLEGER: No.

MR. ROTH: Your Honors, at this point, may I introduce to the Court the Curriculum Vitae?

JUDGE GIBBONS: Yes, what is your next number?

MR. ROTH: I am not sure which Exhibit number it is.

JUDGE GIBBONS: You will take care of giving it a number and let us know.

MR. ROTH: Thank you.

Continued Direct Examination

BY MR. ROTH:

Q. Doctor, have you participated in the admission of juveniles at your institute?

A. Yes, I have.

Q. Would you please explain how a juvenile is admitted at your institute?

A. Fine, let me explain—first of all, give a general overview and then give a view of my procedure of evaluation of a juvenile.

(150) In general, the Institute, which is a private psychiatric facility, receives patients upon referral either

Now, in case of pressure of time, this process may be established—may take place during one day and even in the most serious and complex instances, it might require a couple of hours to make this evaluation. Where there is more of a luxury of time, we may stretch out this evaluation over a several day period.

Only when I have made such an evaluation, will I recommend or not recommend hospitalization.

Q. Doctor, what percentage of those juveniles whom you see, do you advise institutionalization for?

A. I think 60 to 70 percent. Roughly 30 to 40 percent of those who are brought to me or come to me for evaluation, it is my recommendation that other forms of treatment or (152) occasionally no treatment should be the choice.

Q. And, have you had situations where the parent insists on institutionalization?

A. Yes, I have, in the face of my not recommending institutionalization. Is that correct?

Q. That's correct or in the alternative where they indicate at the outset they want to put their child into your institution.

A. Yes.

Q. And, what do you do then?

A. If I do not feel that the young person demands or needs hospitalization, I certainly will not admit that young person even if the parents are absolute in their demands.

Q. Just traveling along this path where the parent comes with his child, do you find that the child generally objects to being admitted when you are recommending admission?

from a base service unit, other institutions or from private referrals in the area.

They may come from within the Philadelphia area or they may come from as far away as the West Coast.

So most young people who come to the Institute, come having been seen prior to arriving at the hospital.

Before anyone can be admitted to the Institute, they have to be seen and evaluated by one of our attending staff at the hospital and then he either concurs or disagrees on the question of admission for that young person and at the time of admission, the young person and his family are seen again by at least the resident psychiatrist prior to admission and then, in the days following admission, and I am talking about 24 to 48 hours, he is seen at least by one and often more likely a half dozen other psychiatrists who are members of the staff of the Institute.

Now, my procedure and I think it is important to mention this, in evaluating a young person, is as follows:

Parents will often initiate the request for evaluation and they will often come to me requesting (151) or stating that their child is mentally ill and requesting hospitalization, but simply because a parent requests hospitalization is no reason that of necessity we will go along with hospitalization as a part of my evaluation, my standard procedure is to first of all see the child with his parents and preferably with any other siblings, if they are available or can be brought in for that evaluation and then next, I would like to see the child individually, alone, and then I would like to see the parents alone, and finally, in this four-step procedure, I would like to see the entire family together, prior to my deciding on the question of admission to the hospital.

A. We are talking now about young people who are evaluated and are deemed in need of hospitalization?

Q. Yes.

A. I think our adolescent unit admits between 60 to 75 patients per year and since its inception in 1966, it has done this, and depending upon whom you talk to, between 90 and 99 percent of those adolescents admitted to the (153) hospital object and at the time of admission, to admission. So, we see that the percentage of those who object is very, very high.

Now, one must evaluate carefully the nature and the quality of that objection, and one must see, if I can make some generalizations about the common aspects of those objections.

First of all, a young person is liable to be frightened, absolutely frightened by the thought of his having a mental illness and by the thought of his having to go into a hospital, a mental hospital, and we all know what stereotypes there are that abound about mental hospitals, asylums, looney bins, et cetera.

Secondly, young people, adolescents, are in the stage of development where they are in the process of separating and individualizing themselves away from their parents, away from their family of origin, and any number of writers in the field, experts in the field, have commented on the fact that essentially in this process of separation, et cetera, the young person uses the defense mechanisms of projection and externalizations, that is, commonly, he blames his faults upon the world, whether they be the world of his parents or the world of his family, the world of his school or the world at large and so, commonly, you will hear the young person (154) say that it is not he who

should be here, but it is his parents or it is—commonly, the parents and occasionally a sibling. These are two general themes that commonly underly the objections that a young person brings with him.

Q. Doctor, are you familiar with the juveniles who have been admitted to the Institute of Philadelphia in the past two to three years?

A. Yes, I am.

Q. Are all the admissions of these juveniles reviewed with you?

A. Most of them, certainly, yes.

Q. Doctor, have I advised you that the Department of Public Welfare sent a questionnaire regarding admissions of juveniles to mental health, mental retardation facilities, last year?

A. Yes.

Q. Have I advised you that one of the questions asked was: "What was the reason for the juvenile's admission or commitment or precipitating behavior warranting admission or commitment?"

A. Yes.

Q. Have I indicated that we received, briefly, responses from your Institute?

A. Yes.

(155) Q. Have I asked you to review the admissions of these juveniles?

A. Yes, you have.

Q. I would like to refer to the prehearing order and in particular to page 15, where it was indicated, "Children have wound up at institutions for the following reasons in addition to their being mentally retarded" and with reference specifically to the Institute of Philadelphia Hospital, Dr. Tashjian, could you please indicate the nature

of the admission of 949433, where the reason given by the Institute is family conflicts?

MR. FERLEGER: Objections, your Honor, unless he has with him the patient's records which can be examined with a court order for confidentiality.

I don't see how unless he testifies that he has been personally involved with that patient and has some foundation that he can testify to that.

There is no way I can lay any groundwork for cross-examination about a particular patient.

JUDGE GIBBONS: What is the purpose of the offer?

MR. ROTH: Your Honor, I wanted to show that I believe there's been an implication made by plaintiffs that, based on the description of the precipitating behaviors that was the sole reason and there is (156) nothing beyond that and I wanted Dr. Tashjian, who has already testified that he has reviewed the juveniles that he was the associate director for of the adolescent unit whereby these juveniles came through his review, and I wanted him to testify with regard to any conditions that may have warranted an admission.

MR. FERLEGER: If I may respond, that point of view was raised in Judge Huylett's chambers and Judge Huylett ordered that Mr. Roth supply a sample of 10 fuller records which he has already supplied and which we don't object to, so whether or not the statement reflects, the reality is so.

MR. ROTH: I am not trying to bring in record of other patients. I am not trying to say one was exclusive of the other.

When we were before Judge Huylett, as I recall, plaintiff and I had agreed that we could select the profiles of 10 patients with regard to pre-admission notes. At that same time, I don't think I excluded the possibility of have any expert witness testify as to the reasons of the admission of any juvenile.

JUDGE HUYLETT: Would you gentlemen indulge us for just a moment, please?

JUDGE GIBBONS: I don't think we need detailed testimony on this particular case. The prehearing (157) order provided for the production of the 10 samples and I think for the purposes of this lawsuit, that is sufficient.

MR. ROTH: All right.

Continued Direct Examination

BY MR. ROTH:

Q. Doctor, let me ask you this with regard to admission of patients in your Institute.

For example, if a patient comes in and one of the problems seems to be weight loss, what other reasons could be indicative of the admission of that patient?

A. Let me first respond in a general way that the reason for admission, and this is something every medical student is taught, during his first and second year of medical school in history-taking is, a composite of the patient's chief complaint which one must take down verbatim, so if you ask the patient, "What brings you here?" and the patient responds, "The trolley.", the doctor would put down the concrete inappropriate response of "The trolley" for chief complaint, and then the physician would sometimes use a few words to describe reason for admission.

Now, it may be because of—let me use a general medical example first before I get to the psychiatric example. It may be for bellyache or abdominal pain. So we have that as the reason for admission—abdominal pain let us say. That can vary all the way (158) from abdominal pain secondary to a hangover from the night before or from having eaten hot peppers to an inflamed ulcerous state and it runs a wide gambit, so to respond to your question specifically about weight loss, that in and of itself that as a reason of admission is drivel unless clarified and amplified.

There are serious—extremely serious, life threatening psychiatric conditions which have as their presenting complaint weight loss.

Q. Would that necessarily hold true for children who come to you that are labeled "runaways," or in conflict with their parents or anything of that nature?

A. Absolutely.

Practically every family with teenage kids knows what it is to experience conflict and in and of itself, family conflict is universal. One has to evaluate the quality of that conflict, the degree of that conflict, the lack of resolution—potential resolution of that conflict and to go back to my evaluation as I said, of an adolescent, that would include

evaluation of family members. It would include looking to what the parents bring to the situation that impinges upon the young person who is designated as the patient or patient-to-be and at times it may be tremendous.

Q. How do you distinguish non-emergency from emergency?

(159) A. I think the Mental Health and Mental Retardation Act of 1966, states that if a person is suicidal or homocidal, that qualifies as an emergency condition.

So, in argument from that standpoint, everything else falls into a relative non-emergency situation, but within non-emergency situations there are those situations where one has the luxury of time on the one hand and on the other hand, there are those situations where one really does not have the luxury of time—where something must be done posthaste—lest the situation escalate or inflame into a potential emergency situation.

Q. In your opinion, Doctor, do you see any advantage of having a parent admit his child to the Institute or in the alternative, having to undergo a judicial proceeding, whereby the parent and juvenile are acting in adversary roles of one another?

A. Again, I want to clarify, and this may seem like nit-picking, but the parent, maybe in a legal sense, does admit the child, but in a psychiatric medical sense, does not admit the child.

The child does not come in because the parent wants the child to come in. The child only comes in after two individual evaluations, at least, and oftentimes in the young people that we are dealing with, they have had several evaluations. They have also had trials (160) of treatment

elsewhere before they are brought to the Institute, before that is considered. I think this;

I will go back to what I said earlier, that 90 to 99 percent of the young people who are admitted to the adolescent treatment center protest in some form or another.

Now, I am sure that if we were to offer—if we were to offer the possibility of having an adversary type hearing, if that was available prior to hospitalization, that a good percentage of those might elect such a hearing, but what happens, once the young person is in the hospital and immediately upon hospitalization, he is informed of his rights in a humane manner by members of the staff and according to Title 55, we carry that out to the letter, that once a young person is hospitalized, of the 90 to 99 percent who objected prior, the overwhelming majority have accepted hospitalization and give up their protests, even though the free legal counsel is available to them just for a phone call, and a free phone call at that.

Now, why does this happen? It happens for a number of reasons. One of them being that most young people are ambivalent in terms of their needs to be hospitalized. Most young people, where the admission is appropriate for psychiatric reasons—again, if I can digress (161) for just a second—no, I will come back to that later, excuse me.

There is an ambivalence and once, in a sense, put into a situation, then a large part of the struggle is over. Once a young person also gets into a situation and finds it is not such a fearful situation, that he is going to be treated humanely, and once the young person has the opportunity to talk with other young people, his peer group,

who are hospitalized there themselves, that these are some of the factors that we think significantly cut down the degree of objections that take place among hospitalized adolescents within the first 24 hours of hospitalization.

Q. Do you feel that juveniles should be able to admit themselves?

A. No, I do not.

Q. Why do you feel that they should not be able to admit themselves?

A. I am aware of Senate Bill 1239, Senator Coppersmith's bill. I have participated in helping to shape that bill and I am aware in that bill in dealing with minors, there is the question of whether 14 year olds should be looked upon as if they had reached their majority, and again, from a psychiatric standpoint a 14 and 15 and 16 year old has not really reached his majority; that in the process (162) of his development, in the process of his separating himself off from the family of taking an individual autonomous stance with himself, some of the things we lump together under the general rhetoric in the process of his developing his personal sense of identity, the young person is in conflict commonly with his parents and I would point out to you that how many of us sitting in this courtroom were not at some point and at time maybe in a major way in conflict with our own parents in the process of growing up and how we now look back upon that conflict.

I don't feel that minors have the judgment to decide for themselves when they want to see a psychiatrist and when they don't want to see a psychiatrist. I feel that they can aid and collaborate in that judgment. I feel that they have a voice and that voice must be heard. I feel it is an essential voice, but I do not feel that a young person in

and of himself, by himself, can make a decision of that magnitude.

Q. If a juvenile presents himself or herself at your Institute and seeks help, what would you do?

A. Okay, what would I personally do?

There are some of my colleagues who might do differently. If that young person saw me—requested to see me, I would see him. For the purpose of ascertaining his complaint. If I felt his condition required (163) emergency measures, then I would attempt to contact his parents and any other authorities necessary to protect him. Whether that young person wanted me to contact his parents or not. I, personally, would not undertake to treat that young person unless he allowed me to make contact with his parents and to see his parents and have commonly, my experience to include his parents in the treatment. If we are going to talk about family systems, as the previous witness has, in terms of seeing the family system as the nucleus, then, it is important that we not allow any one member of that nucleus to fail, whether it be the young person or the parents.

Q. Have you taken part in the hearing for institutionalizing of juveniles?

A. Yes.

Q. Do you feel that hearing is traumatizing on the juvenile?

A. Yes. It damages what is usually a weakened family situation. It pushes that family to the wall even further. Oftentimes, when a young person is in distress and his family is in distress, there is a lot of acrimony, a lot of verbal violence, occasionally some physical violence and a lot of hate and in my experience, going to a Court and having an adversary situation escalates that.

The second point I'd like to make is what (164) is the Court to ascertain? It's been mentioned here that the Court is to ascertain the facts. Again, I am not comparing us with lawyers, but physicians from the early days in medical school are taught in history-taking and I did this both as a student and teacher when I was teaching medical students at the University of Pennsylvania, are taught to assess the reliability and validity of information gotten from the patient and other informants who talk about the patient.

When I talk with the parent and the parent tells me that Linda Sue wants to go to the dance, rather than stay home and study, I feel a competency to evaluate the truth of this and by the way, I am going to get Linda Sue in and have her respond to this and I am going to look at the equality of the complaint and sometimes I am going to hear some very absurd complaints.

I, as a physician and psychiatrist, am in a position to evaluate this. If the other point is in addition to facts, we are here to evaluate the mental status of the individual, something that is more intangible, something to be sure does involve judgments and is subject to error, but we are here to evaluate the motivation, the mental status and the whole emotional make-up that lies behind the behavior that the young person presents and the complaints that the family expresses and may have.

(165) So, again, we may have a young person whose reason for admission is that she is hospitalized because of family conflict and we would say, "My goodness. How unfair it is to do this." We have to go deeper; what is the nature of that family conflict? How is that individual, the so-called designated patient, affected by that family

conflict? How profound is her disturbance? How is it likely to continue if she remains within the confines of that family? Is there a possibility that one as an outpatient can get a hold of this family in treatment or the parents in treatment or does one make a treatment that one can't get a hold of soon enough and if one lets one go, might she not suffer great harm?

To use an analogy, someone is made very sick by, let's say, the escape of chlorine gas as occasionally happens here in Philadelphia and other places. Now, to deny that person hospitalization, because the reason for admission is chlorine gas, when you really want to get and bottle up the cannisters of the train cars of chlorine is absurd. One has the responsibility to protect and to treat the individual once one makes a decision that that individual is suffering from severe emotional disturbance whatever the causes are.

Q. Doctor, your Institute, I would assume, is fairly expensive per day; is it not?

(166) A. Yes.

JUDGE HUYETT: What are the daily charges, roughly?

THE WITNESS: Roughly in the area of $110.00, $120.00, $125.00 a day. I must say it is not—well, that sounds defensive. I'll let it stay.

Q. Have you ever found yourself in a situation where a patient required in-patient care at your Institute, however, the family finances or insurance coverage was not able to meet all these costs and you had to recommend another institute or an institution?

A. Yes, I have.

Q. Have you ever recommended a state institution?

A. Yes, I have.

Q. And, what state institutions have you recommended?

A. Norristown and Haverford State Hospitals.

Q. Do you find that out of those institutions, when you refer a patient, that the patient is then evaluated by the staff at either one of those hospitals?

A. Yes.

Q. Do you find that at those hospitals, the psychiatrists are not only looking to the prospective or designated patient, but also they look to the family?

A. Yes, that's been my experience.

Q. What I am trying to get at, Doctor, as a private
(167) psychiatrist at a private facility, as you may have heard before, there was some claim that psychiatrists at institutions do not involve themselves with the family and look strictly or focus strictly on the designated patient; is that your experience?

A. I think what we are talking about as a new trend in adolescent and child and general psychiatry, of looking at the family system, which is a derivative of the so-called "general systems" theory and it's been my experience that this is common knowledge now to anyone in psychiatry who has been doing any reading at all in the last 10 years.

Q. Doctor, do you have any idea how many juveniles have objected since September of 1973, roughly in your institution?

A. Objected—

Q. To their admission—

A. To the point of contacting—

Q. A lawyer, yes.

A. Of let's say roughly 75 patients in that time, maybe a dozen have objected to the point of contacting a lawyer, and I think two or three objected to the point of going for a Court hearing.

MR. ROTH: I have no further questions, your Honor.

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(168) *Cross-Examination*

BY MR. FERLEGER:

Q. Dr. Tashjian, you mentioned charges of $120.-00—

JUDGE GIBBONS: Do you expect your cross-examination to be prolonged?

MR. FERLEGER: Probably at least 20 to 30 minutes, your Honor.

JUDGE GIBBONS: As I told you earlier, that won't be possible and since the Doctor would have to then return in any event, perhaps we should recess now.

MR. FERLEGER: Certainly, your Honor.

JUDGE GIBBONS: We will resume Wednesday morning at 9:30 A.M.

MR. ROTH: Dr. Tashjian will commence at 9:30 Wednesday, be the first witness and he will continue his cross-examination?

JUDGE GIBBONS: Usually, when I grant a recess before cross-examination, it prolongs the cross-examination. Think about that carefully.

MR. FERLEGER: Thank you, your Honor.

JUDGE BRODERICK: You mean you want him to be different or not to be?

JUDGE GIBBONS: It is usually not useful.

MR. FERLEGER: I will just note that I have given the Clerk, you might want to take with you, copies (169) of the deposition of Dr. Barbara Armstrong.

JUDGE GIBBONS: Would you take care of, today, of getting the Exhibits marked?

MR. ROTH: Yes.

(Whereupon, at 3:55 P.M., Court was adjourned until 9:30 A.M., Wednesday, September 11, 1974.)

EVIDENTIARY HEARING
SECOND DAY

Philadelphia, Pa., September 11, 1974
(9:30 a.m.)

Before:

Hon. John J. Gibbons, C. J.

Hon. Daniel H. Huyett, 3rd, J.

Hon. Raymond J. Broderick, J.

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(172) (All Counsel and parties being present, the following transpired in open Court.)

JUDGE HUYETT: Good morning, gentlemen.

JUDGE GIBBONS: Good morning.

JUDGE BRODERICK: Good morning.

MR. FERLEGER: Good morning, your Honors.

MR. ROTH: Good morning, your Honors.

JUDGE GIBBONS: Mr. Roth, are you ready to proceed?

Mr. ROTH: Yes, your Honor.

On Monday afternoon, we had completed our direct examination, as I recall. We have no further questions.

JUDGE GIBBONS: Dr. Tashjian, would you resume the stand?

(LEVON D. TASHJIAN, previously sworn, resumed the stand and testified further as follows:)

Cross-Examination

BY MR. FERLEGER:

Q. Dr. Tashjian, how many psychiatrists do you have on your adolescent unit at the Institute of Pennsylvania Hospital?

A. There are two sets of answers for that.

In terms of administrative responsibilities for running the unit, there are four Board qualified or Board certified psychiatrists. At least two and usually four residents in the second year of psychiatric training and there are a number of attending psychiatrists who are on the staff of the Institute who admit—

Q. How many are they?

A. Well, there are approximately 160 psychiatrists associated with the Institute.

Not all of these psychiatrists by any means work with or treat adolescents, and I would say maybe we draw from a pool of 30 or 40 attending psychiatrists.

Q. How many other treatment staff are there, approximately?

A. In the—

Q. In the adolescent unit.

A. We have a very large treatment staff. We have a certified and accredited school with a faculty of 12 to 15. We have multi-disciplinary recreational and therapy departments with a staff of four to five, plus a good complement of nurses.

Q. Your program there is a rather unique program in the city, isn't it?

A. We think so.

Q. And, I would guess from what I have heard, since we sought you as a witness for our side, that your program is rather unique in the country; would you agree?

(174) A. No, I think that there are—we think it is a darn good program and we will match it with programs—

Q. Is the program in most of our state hospitals for adolescents?

A. I think so; yes.

Q. You mentioned that you refer people who can't afford the $120.00 a day fee to Norristown State Hospital or Haverford State Hospital; is that right?

A. Yes.

Q. Do you refer people to Philadelphia State Hospital?

A. I have not had occasion to.

Q. Why not?

A. Because people—well, my patients—primarily, because those patients with whom I would refer have not fallen into that catchment area.

Q. Isn't it another reason that Philadelphia State Hospital does not have an adolescent program; it isn't such a good hospital to begin with?

A. I have no direct familiarity with Philadelphia State Hosiptal.

Q. What is its reputation?

A. It's reputation is pretty much as you describe it.

Q. Dr. Tashjian, I am asking these questions, because you testified about your procedure and you emphasized the word, "your" for admitting adolescents. You don't (175) have any knowledge of the procedures at Philadelphia State Hospital or other state hospitals around the

state, except for Haverford and Norristown; isn't that right?

A. In general, yes.

Q. Yes, you do not have knowledge?

A. Yes, that's true.

Q. So, that when you testified that you do a full-day evaluation, you do not know if the state hospitals or state facilities for the retarded which typically have fewer staff, you don't know if they are as extensive as you are personally in your evaluations; isn't that right?

A. No, I must say, if I can state this, that I do a fair amount of teaching and in the places that I do teach, I do recommend my form of evaluation as a standard form of evaluation.

Q. I understand that. I hope your students follow your recommendation.

Now, Dr. Tashjian, with regard to the replies that your Institute made to the defendants' interrogatories which will be part of the record in this case, you testified that you were familiar with those replies; is that right?

A. Yes.

Q. And, you are aware, are you not, that those replies indicate that in 1972, there were no Section 406 Court (176) commitments to the Institute; is that right?

MR. ROTH: Objection, your Honor.

Dr. Tashjian testified with regard to the particular patient profiles that I had alerted him to. He has not said on direct examination that he was aware of all the responses to that questionnaire.

MR. FERLEGER: Mr. Roth, can we stipulate that this is the response and no Court commitments were reported by the Institute of Pennsylvania Hospital in 1972?

To save time, let me withdraw that question.

Q. Isn't it correct, Doctor, that the Institute generally receives few Court commitments of juveniles, most of your patients are voluntary, signed in by their parents; isn't that right?

A. Most of them come in under a 403, rather than a 406.

Q. Most of them, as you testified, are people whose family can afford $120.00 a day, plus additional costs; is that right?

A. Yes, either because of personal monies that they have or health insurance that they have of one form or another.

Q. So, you do not have the experience with lower middle class or lower class people who form most of the patients in our state hospital system; is that right?

(177) MR. ROTH: Objection, your Honor.

It's not been established that lower socio-economic backgrounds are the primary persons who are in the institutions.

MR. FERLEGER: I think the Court can almost take judicial notice of the fact that people in state hospitals are not the people who can afford the $120.00 a day that the Institute charges.

JUDGE GIBBONS: No, I don't think I can. Sustained.

Q. Dr. Tashjian, you testified that 90 to 95 percent of the juveniles who are sought to be admitted to the Institute object to being there—

A. To being brought in there.

Q. To being brought in there?

A. Yes.

Q. Now, Dr. Tashjian, what proportion of those juveniles do you feel are competent to voice an objection?

MR. ROTH: Objection, again, your Honor.

I am sorry, it is misleading. However, Dr. Tashjian testified approximately 99 percent voiced an objection.

JUDGE GIBBONS: Well, 99, 95, of those who voice an objection, what percentage in your opinion are competent?

(178) THE WITNESS: I don't know what either of you mean by "competent." I'd like to answer that question, but I would like a clarification of what you mean by "competent."

Q. With regard to the individual case that you were going to testify about and with regard to your institution's responses to the interrogatories, are you aware of the fact that your institution noted "yes" or "no" with regard to the question of competency?

JUDGE GIBBONS: I think you have to show that to the Doctor.

MR. FERLEGER: Certainly.

JUDGE GIBBONS: In the second place, I think his objection to your question is well taken.

Do you mean competency in the legal sense or in some other sense?

Q. Dr. Tashjian, by "competency," I mean competency to object, whether that juvenile had the capacity to voice an objection and know that that person was objecting to being in the institution.

A. Okay, I am aware—competency in medical or psychiatric sense, that the person's disturbance was not such so that there was extreme confusion or extreme disorientation of thought. In that regard, I would say that they were competent.

(179) Q. How many were competent; what proportion?

A. Just scanning over the list, I would say the majority were.

Q. Dr. Tashjian, adults also object to being in mental hospitals; isn't that correct?

A. Yes.

Q. And, a certain proportion of those adults are competent in the sense we have been using it and another proportion are not competent to object; is that right?

And, Dr. Tashjian—

JUDGE GIBBONS: Just a moment. When you nod your head, the court reporter won't pick up that. He can't see you.

Please respond audibly.

A. Could you start again, so I will know what I am—

Q. Dr. Tashjian, you just nodded your head affirmatively to the question of whether or not some proportion of adults who object are competent and some proportion are incompetent.

A. Yes, from a medical and psychiatric standpoint.

Q. When adults object to involuntary commitment, you understand the law, do you not, the law in Pennsylvania is that they are entitled to a commitment hearing under Section 406; is that right?

A. Yes.

(180) Q. Dr. Tashjian, is it not possible that—

MR. FERLEGER: Strike that.

Q. Dr. Tashjian, you testified that participation in Court hearings weakens an already weakened family situation and that in those family situations—this is with regard to juveniles—there is already verbal violence or physical violence.

Now, I take it that your testimony is that in many of these cases, we don't have a typical, normal, stable family; is that right?

MR. ROTH: Objection, your Honor.

I don't believe that Dr. Tashjian has testified that a hearing weakens an already weakened family situation.

MR. FERLEGER: I have notes of three separate people and I think the record will indicate what his testimony is.

JUDGE GIBBONS: I recollect that he did so testify.

JUDGE BRODERICK: It is my recollection. He may not have testified in those exact words but that is the impression I got.

Let's ask him if he so testified.

THE WITNESS: My recollection is that I did testify that way.

(181) JUDGE BRODERICK: Very well.

Q. You will agree that these situations, these families who were in this turmoil, who seek to have a child admitted to the hospital, you would agree these are not

the normal, stable, healthy families from a psychiatrist's point of view?

A. I would have to qualify that in the sense that the impression can get around that families of disturbed adolescents are monstrous in their deviation from the norm.

I would qualify it by saying that families can have any one of us as parents, that family structure can be weakened by crises, can be weakened by family crises, can be weakened by crises among one or more of the family's members in the family during this time. I don't want the Court to have the impression that families of disturbed adolescents are beyond the pale. If that distinction is clear, that then I would say, yes, that families of disturbed adolescents are often themselves disturbed.

Q. Dr. Tashjian, I want to show you a piece of paper marked plaintiffs' Exhibit 8.

MR. FERLEGER: I have three copies for the Court.

JUDGE BRODERICK: All right.

(182) JUDGE GIBBONS: Plaintiffs' Exhibit 8 for identification?

MR. FERLEGER: Yes, your Honor.

Q. Do the photographs in plaintiffs' Exhibit 8 for identification accurately reflect facilities at your Institute of Pennsylvania Hospital?

A. Yes, they do.

Q. Now, Dr. Tashjian—

A. Tashjian.

Q. Excuse me.

In plaintiffs' Exhibit 8, you notice a list of activities that are available at the Institute.

Would you read that list to us and indicate whether that list is accurate?

MR. ROTH: Objection, your Honor.

I find this questioning is irrelevant.

MR. FERLEGER: I am willing to explain, your Honor, that the purpose—

JUDGE GIBBONS: We know your purpose. You are making the point that the facilities at the Institute are not typical.

MR. FERLEGER: The further point I wish to make, your Honor, is with reference to Dr. Tashjian's testimony that children once they get there don't want to leave; that the reason may be that because the situation (183) is so much more attractive and so much more playful than their own homes—

JUDGE GIBBONS: I don't think you need to pursue this any further.

MR. FERLEGER: Okay.

JUDGE GIBBONS: I have made the point that this private institution is more luxurious than state institutions.

MR. FERLEGER: No further question, Doctor.

JUDGE GIBBONS: Mr. Roth?

MR. ROTH: Just a few questions, please.

Redirect Examination

BY MR. ROTH:

Q. I believe Mr. Ferleger indicated on cross-examination that he sought you as a witness; is that correct?

A. Yes, it is.

Q. Why did you not appear as Mr. Ferleger's witness?

A. Well, I weighed very carefully both sides of the case at hand and decided that my own philosophy, my own professional beliefs lay more on your side than on his side.

MR. ROTH: No further questions, your Honor.

JUDGE GIBBONS: Doctor, is it fair to say that respectable psychiatric opinion exists which would (184) differ from your own as to the issues in this case?

THE WITNESS: Yes. Yes, it is, sir.

JUDGE GIBBONS: From the medical or psychiatric point of view, rather than from a due process point of view, is there any medical or psychiatric reason for distinguishing between adolescents and young adults for purposes of a precommitment hearing?

THE WITNESS: Are you defining an age point, sir, in the distinction?

JUDGE GIBBONS: Suppose you define an age point. I think the law defines the age point as 18.

THE WITNESS: Well, if we say adolescents are 13 to 18 and young adults from 18 up to 25, yes, I think there are medical and psychiatric reasons for making such a differentiation along the lines which

I have sketchily presented Monday, that it's presumed in general—and certainly there are exceptions in both sides of 18—that a young person by the time he would have reached his 18th birthday, will have navigated the major issues of his developing into an autonomous person and developing a personal sense of identity which is separate and distinct from that of his family.

It is presumed that he will in a psychological sense have reached maturity and be able to make judgments in his own regard.

(185) JUDGE GIBBONS: I suppose you would testify that for the under 13's, it is a fortiori case that they have not reached that state of development?

THE WITNESS: I don't understand the term, sir.

JUDGE GIBBONS: Let me ask it this way.

Would you make the same distinction between young adults and children under 13?

THE WITNESS: Yes, I would, because the child under 13 has much less developed psychologically than the adolescent.

JUDGE GIBBONS: Thank you, Doctor.

MR. FERLEGER: If it please the Court, for the purpose of the photographs Dr. Tashjian has identified, I move the admission of plaintiffs' Exhibit 8.

JUDGE GIBBONS: For what they are worth, it will be admitted in evidence.

(Whereupon, the brochure referred to above, was marked plaintiffs' Exhibit 8 in evidence as of this date.)

MR. ROTH: Dr. Miller.

DEREK HARRY MILLER, sworn.

THE CLERK: Would you state your full name?

THE WITNESS: Derek Harry Miller.

JUDGE GIBBONS: Mr. Roth, would you please (186) keep your voice up today. We had a little difficulty hearing you on Monday.

MR. ROTH: Yes, your Honor.

Direct Examination

BY MR. ROTH:

Q. What is your profession, please?

A. I am a physician and psychiatrist.

Q. Are you licensed to practice medicine and psychiatry?

A. Yes.

Q. Where are you licensed?

A. I am licensed in Michigan. I am licensed in parts of Canada. I am licensed in Great Britain and Northern Ireland and various dominions.

Q. What medical schools are you a graduate of?

A. Leeds, England.

Q. Where did you intern?

A. I interned at Leeds University and another internship in Canada.

Q. Where did you perform your residency?

A. In Canada and a residency in the Menninger Foundation, Topeka, Kansas.

Q. What is your medical specialty?

A. Psychiatry and in particular adolescent psychiatry.

Q. What specialized training have you received in the field of child psychiatry and adolescent psychiatry?

(187) A. When I was a resident in Topeka, we had a special course in child psychiatry. We did not, in those days, have a special course in adolescent psychiatry.

Adolescent psychiatry is a relatively new subdivision of child psychiatry or psychiatry as a whole and I would have to say that my learning in adolescent psychiatry was one which I guess I sort of led the field in with a group of other people and that I and some other psychiatrists, in the 50's, started to work very significantly with adolescents.

There had been some work before 1939, but not very much.

Q. Doctor, are you a diplomat of any Board of Psychiatry?

A. Yes, I am a diplomat in Great Britain in that I am a member of the Royal College of Psychiatrists.

I also have a higher medical qualification in psychiatry. That is to say, in Britain, you graduate in medicine with an M.B.

I have also an M.D. It is like a Doctor of Medical Science in this country. It is sort of one-up on the standard medical degree, if I may put it that way.

Q. Doctor, have you ever taught psychiatry?

A. Yes.

Q. Have you ever taught adolescent psychiatry?

(188) A. Yes, indeed.

Q. Where have you taught adolescent psychiatry?

A. I taught adolescent psychiatry in England at various colleges of the University of Sussex, Oxford, Cambridge and at the Tavistock Clinic which is a private non-profit-making foundation in England which is run by the National Health Service and is unique in the world.

In this country I teach at a number of universities. I teach at a regular basis at the University of Michigan.

Q. What is your current position?

A. What?

Q. Where is your current position and what is it?

A. Currently I am chief of the adolescent service at the University of Michigan in the Department of Psychiatry. I am associate chairman of the Department of Psychiatry.

Q. Have you authored any psychiatric articles or books which have been published.

A. Yes, a great many.

MR. ROTH: At this time, your Honors, I would like to introduce into evidence Dr. Miller's Curriculum Vitae, which I have marked as defendant's Exhibit 11.

JUDGE GIBBONS: Would you show it to (189) Mr. Ferleger?

MR. ROTH: Yes.

JUDGE GIBBONS: It will be admitted.

(Whereupon, the Curriculum Vitae of Dr. Miller was received in evidence and marked defendants' Exhibit 11 as of this date.)

JUDGE GIBBONS: I hear no objection; is that correct?

MR. FERLEGER: That's correct.

Continued Direct Examination

BY MR. ROTH:

Dr. Miller, how long have you been practicing child and adolescent psychiatry?

A. Since about 1955.

Q. Does your practice include family psychiatry?

A. I don't believe you can treat adolescents without also treating families.

Q. Doctor, throughout this hearing, the terms "child," "infant," "youth," "adolescent," and "juvenile" have been used interchangeably.

Would you please tell us when these terms come into being in connection with human development?

A. Yes, broadly, many of these terms as you know, as is always the case in the English language, are used multiply.

One looks at infants as human beings up (190) until the age two. The word "child" is used, interestingly, sometimes for people up to the age of about 18. Although I think from a medical point of view it probably makes more sense to talk about a child as being a human being up until the age of puberty. "Adolescence" is a stage of development and within that age which is crudely considered to cover the teenage years, there are at least three developmental periods which are sharply defined.

There is a period which lasts about three years in which we are responding to the physical changes of puberty. If you are going to put age norms on, this period ends

at about 14, 15. At about the age of 14, 15, in Western society, generally human beings begin to get interested in a fairly significant way in things that go on outside the family. Generally, the great flush of growth is over.

There is another stage of human development which is middle adolescence, a period in which we are learning to get a sense of ourselves and that lasts about three years and during this period of human development, we are beginning, as it were, to ease ourselves away from our families, although, interestingly, we get very conformist to family norms.

The 15, 16, 17 year old, roughly in this period, is not rebellious at all. They are really very (191) conformist and the last phase of adolescence is one of the periods which is not related to physical growth, and that is a peculiar development associated with our society in which we give people an interesting moratorium. We say, "You must train for certain adult roles in society, but while you are training for these roles in some way, we insist on treating you as if you were not yet adult."

For example, we do this with money; we do this with responsibility about marriage, and so on. So you get a rather prolonged period called "late adolescence," in which people learn to cope with the identity they have already got. Within this period there is a fluctuating relationship to families. That is, through the pubertal period, I would say that in terms of human development, you'd have to say that the family-peer relationships and extra parental-adult relationships are all extremely significant and the family needs to be reinforced in its values for the child by what adults and social networks who are not in the family say about the family, if I make the point.

After the age of 15, a healthy—15 is arbitrary because it may be 17 in some people—after the age of 15, the family as it were is a very necessary back cloth against which development will take place. Having had your healthy family hopefully, about the time (192) you are 15 or 16, you are ready to launch into society somewhat, but you still need to check back, if I can put it this way, with your family.

Now, with children or adolescents who are psychologically disturbed, the family relationships clearly are different. Insofar as adulthood is concerned, there have been interesting definitions of it. One definition is, which I think is nice, by the time you are an adult you are able to predict the likelihood of your prebehavior insofar as it will affect your future possibilities. Or, by the time you are adult, you are able to tolerate being frustrated without necessarily inflicting pain on other human beings. You are adult when you are able to hold your worries and hold your anxieties and not make other people suffer, because of your psychological pain.

Q. Are adults and adolescents psychologically the same?

A. No, they are psychologically quite different.

Perhaps a good demonstration of this would be the issue of the relationship of human beings to time. For example, an adult, and I am talking about a healthy adult, generally has a fair concept of the future. An adolescent is still rather present oriented.

Now there are different developmental rates in men and women. Women reach adulthood chronologically a year or two before men. So, for example, you constantly (193) get into trouble on campuses when young couples

live together as they currently do in that the women often, they have a great sense of the future and they say and feel, if you really loved me, you would want to live with me forever. The young man of 18, 19, in this late adolescence phase still doesn't have a great sense of the future and they are very much wanting things here and now and get anxious, but people start talking about what you do now will affect you or should go on for a very long time. There are many examples.

Q. You have talked in terms of the normal adolescent and adult.

How would that be viewed in terms of the abnormal or the disturbed, if you will, adolescent and adult?

A. There is a very important point about disturbance, that is never ubiquitous in a personality. We have parts of our personality which may be turbulent and cause pain. We may on the other hand have very many healthy parts. It is conceivable, although I trust not, somebody in this courtroom somewhere in their heads can be quite crazy, but there would be no way to know this. It would be that they are showing us the healthy side of themselves.

What we would have to do and this is the grossest generalization, the more adult we are the more (194) we have a healthy functioning personality in terms of being able to be realistic and sensitive, imaginative—not to inflict pain and so on.

If I might, one of the issues which came in an earlier question is relevant to this. The need of adolescents to say "no" to hospitalization is part of being fundamentally enough healthy. An adolescent is striving to be healthy even if they are disturbed, so there are some parts of the personality which are quite healthy and they are struggling

to be independent, to be separate, to be all these sort of things.

So when somebody says to them, "Go into a hospital," they must say, "No," if they have any health at all, because if they don't say, "No," it is like abandoning the ship and it would be like agreeing that I am only a lost, weak, pitiful human being and if you have got any health at all, you are not going to do that.

Q. What is the role made of, of the family in connection with the development of the child in adolescence?

A. The question is frightening in how big it is.

I would say broadly speaking this:

The family needs to provide that sort of loving care and consistency which we require in order to grow. Very specifically, insofar as the development of the sense of ourselves is concerned, our parents, the way (195) they react to each other, the way they react to us, are the models on which we build our personalities. That is to say, we get a perception of our father and mother and both consciously and not consciously, we say, "I would like to be like that." And up until we reach puberty, boys and girls, as you well know, are quite happy often to say, "Yes, I would like to be like my father." Once we reach puberty, when we are trying to separate ourselves which is the process that really begins seriously at puberty and is a very complicated one, particularly boys, go through an elaborate period in which they say, "No. I don't want to be like my father at all. He is square; he is dull."

While they are going through that phase, they are busy looking for adults who strangely they see as being like their father. So they say, "I don't want to be like

my father;" but on the other hand they will find some school teacher hopefully, some minister who they like very much and they will say, "I would like to be like him," and they don't often realize that man in many ways is perceived by them as being similar to their father.

There is a complicated process of modeling in human development which starts with your family relationships and then moves out from your family relationships and what is very important for children is that the models (196) be dissonant. If they are, then the adolescents get very confused. If for example, as can happen, if I might use an example from Britain, if a lower socio-economic class boy or girl gets a scholarship and goes to an English public school which you know is an English private school, the models that they get in the English private school, which is a boarding school, are so different from the models that they have from their parents, that they then get into real confusion about who they are and what they are, particularly if the school staff doesn't support the parents in the way they behave.

Then, the youngsters are really thrown into a real confusion as to who shall I listen to.

Q. Doctor, let's assume the parent brings his child to you. Now, what procedures do you utilize in determining whether or not that prospective patient requires hospitalization?

A. There are really two broad things one can look at, there is the acute emergency which I think is pretty obvious, in which if a child appears—now I am using the word "child" loosely; I am talking about somebody up to the age of 18. If a child appears in any acute crisis which

means that they are being dangerous to themselves or dangerous to other people, then there is no argument about it, we admit them if we have a bed.

(197) We have a policy in our hospital of open admissions and if we have a space we will admit someone. So if it is an acute emergency that presents to our emergency room, we will admit the person. I can go into greater detail because sometimes people come in having made suicidal attempts and they will say they don't need to be here. So, merely being in acute danger to oneself and acutely dangerous to others does not stop an adolescent from saying he wants to be out.

General routine is something like this. We get children referred to us by parents directly. Sometimes by the juvenile court, sometimes by parents via some pressure from the school system, pediatrician or another psychiatrist. Before we will admit, we try to assess and then often these youngsters come with a recommendation for admission and on the day of admission, we will of course try to assess whether the admission seems one, indicated, and two, whether we think that the request is being made to us and that we are the place to be helpful, because sometimes, people will ask for us to take people in and we know we cannot be helpful and then, we will not admit. By the way, although we are a state facility, we differ slightly from the other state facilities in Michigan, in that we can say, "No." This is because we are a teaching hospital, as well. But in a general (198) way, we try to do this:

We try to say to ourselves, "Would this human being be more help-able in our hospital or out of it?" That is one question we ask ourselves.

The other question we ask ourselves is, "Would he be completely unhelp-able if he were out of the hospital altogether? "

Now, that might sound an odd thing to say, but sometimes, we have to admit youngsters to our hospital because they come from the Upper Penninsula, and everybody who knows Michigan knows that is a very long way off and it is too far to travel, so sometimes we get youngsters brought to us and we will admit them for assessment because there is nowhere else for them to go and this puts a particular responsibility on us, I believe and always of course, those boys and girls say, as one would expect, "I don't really want to stay. Let me go home." We will admit boys and girls sometimes under conditions which would certainly not fit the adult commitment laws in Michigan. For example, if we see a boy or girl and if I may use this clinical example, who has been brought to see us, because they are failing in high school and we discover that their high school day consists of moving into the parking lot at a quarter to eight in the morning with some peer and a joint, which is a stick of (199) marijuana, and smoking that and they go on smoking in the high school throughout the day, and this I regret is not as unusual as it ought to be, eventually, you get youngsters who are thoroughly dependent psychologically on marijuana, for example. These boys and girls are not help-able as outpatients, because if I may use the vernacular, they are stoned. If I may be technical, they are intoxicated all the time and you can't relate to these boys and girls while they are intoxicated, so you have to admit them.

As they dry out, you can also begin to get to know them. This is not a cause for commitment of adults, it is

a particular one with adolescents, so we would admit a boy or girl like that.

We would admit a girl to our hospital for example, who was being highly promiscuous, although her other difficulties might not be so catastrophic.

Suppose you have a 14 year old who is being inordinately promiscuous, and in her need to be mothered and cuddled is moving rapidly from boy to boy, frankly collecting cuddling with intercourse the price she pays for it, that child is not help-able as an out-patient, because out-patient treatment always presupposes that the youngster will be able to make a meaningful emotional relationship with whoever tries to treat them and it (200) always presupposes that they will in some way contain their troubles and anxieties to deal with them with the therapist who may be a doctor or social worker or what-have-you and if adolescents are able to go on hurting themselves all the time in this sort of way, we will tend to say, "Admit them," because there is no other way in which we can protect their development and I think the issue with adolescents is different from the issue with adults, because adolescents need treatment sometimes in hospitals to protect their developmental aspect.

Adults, it seems to me, may need to be in a hospital, but generally society adopts the attitude with adults, "We will require you to be in a hospital if we think you are doing certain sorts of things that worry us," but with adolescents, it is an issue of need which is a great deal more complicated.

Q. Doctor, are you aware of the Sections 402 and 403 of the Pennsylvania Mental Health Act?

A. I might get a little muddled about them, but generally I am aware of them.

Q. Are you aware of the additional safeguards for juveniles?

A. Yes.

Q. Could you please tell us, professionally, of what you think of that two-step process?

(201) A. I think it is fine. I have no problems with the two-step process. If I were the receiving psychiatrist, by the way, I would be presenting myself to the child more in terms of trying to make a relationship with them; this is what I want the youngster to feel, that I was trying to make a relationship with them; that I was trying to show them the sort of facilities we have got, which hopefully might be helpful to them in our hospital, where we are, and I think that is as well-staffed as the Pennsylvania Institute, nearly, but physical facilities are awful and really they turn you off in this reception process.

I explain to the youngsters, among other things, what sort of physical surroundings we have and at the same time I would be doing this, I would be assessing whether I thought they really needed to be in a hospital, under some of the terms I have defined.

Parallel to my seeing the youngsters, we always have a professional person see the parents, because there is a funny conflict of interests between adolescents and their parents. Sometimes it isn't helpful if the person who sees the youngster also sees the parents.

We have one of our professional colleagues in our hospital, the day they come in, and by the way, this is a legal obligation in Michigan, they have to be (202) physically examined and so we would do all that and so pretty

much they would be spending a number of hours in the hospital while we are assessing them.

Now, actually, for convenience sake, what happens is, that we start to hotel them on our ward while we are doing this, because they have to have lunch somewhere in all these sort of things. We won't ruthlessly send somebody into town. So the hotelling such as it was, is still going on. It is not limited in our hospital.

Q. Do you feel that psychiatrists and parents operate in a conspiracy to institutionalize or hospitalize their child? Are you aware of any occurrences of that?

A. Yes, I am aware of occurrences because when I became a resident in psychiatry, one of the first things I did working in a state hospital was to happen to be in a ward full of chronic patients and I found an old lady of 45, and she was old before her time, who had been admitted to that hospital when she was 19 for no reason I can establish. She seemed to have been admitted because she had a temper tantrum. I have never in current practice ever come across this.

With the shortage of facilities for adolescents it seems to me inconceivable this could happen, because everybody treating adolescents is in a situation of turning youngsters away.

(203) To my knowledge and I don't know about this state, but getting an adolescent hospitalized in Michigan is an horrendous difficult task because there aren't enough spaces.

Q. Doctor, it has been implied that children are admitted to institutions for the wrong reasons and to protect them a judicial hearing should occur prior to admission.

How would you feel about having a judicial hearing prior to admission?

A. Let me make a point.

I am not against the law and I strongly feel the law should protect the rights of children.

I personally see it as a question of timing. It seems to me the problem is something like this: If a child is going—suppose a child is going into a hospital and on the way he says, "No, I don't want to." That is what one would expect the child to say. That, as I would see it, is the youngster's attempt to say, "I have some autonomy. I have some independence." For the youngster to be sat on with due respect to the Court, by the law and told with the whole majesty of the law, "You must go into the hospital," I fear would be terribly crushing.

That the paradox of the situation is as I would see it, we want to protect the child's right to (204) say, "I don't want to," because that represents health. We don't want to sit on the child's right to say, "I don't want to," because that crushes them and the worst situation you can be in in trying to help an adolescent is to have a passive youngster who won't struggle, because they have given up and, quite frankly, I would be very anxious if the law interceded at that point, because you see, the way we protect a child is this:

Suppose we have a boy or girl in our unit who says, "I want out." Now, that boy or girl has the right now in Michigan to go and get a lawyer which he gets, to go before the Court, which he does. Naturally, he goes before our Juvenile Court and we have in fact—it has to be done under our new Act within seven days.

Now, if the boy or girl has got a good relationship with us, which hopefully he has, and I am using "he" for either, we can and do protect him psychologically while he is going through the process. We have a good working relationship with our Juvenile Court judge who does not sit on the youngster if he says , "No."

We work with the families and help them understand that if, as it usually happens, and it usually does by the way, because we don't keep children who we didn't ought to keep. If as usually happens, the judge says to the youngster, the judge says, "You must stay," (205) we have to explain this to the parents as well. We have never had a child yet, and this may be due to I don't know, perhaps our luck or I like to think our skill, we have not had a situation yet in our hospital in which the judge has removed a child who we say ought to be there. But we don't say a child ought to be with us, lightly. I don't know anybody who does, actually.

Q. What kind of effect would a prior judicial hearing, if you will, have upon the family structure?

A. Well, you know, that's an enormous blanket question, but I tend to think it would be hurtful to family structure in this way. To begin with, assessing a family and assessing a child is quite a complicated business. This is rather a roundabout way of answering the question, but I think it is necessary.

When we admit the youngster for examination, we say to the parents and youngster that the admission in the first place is for not more than four to six weeks, and during that period of time, we would expect to know whether we thought we could be helpful ourselves and if we didn't think we could be helpful ourselves, then, we would suggest some other way in which help was necessary.

Sometimes, you don't keep a youngster four to six weeks because it becomes clear that the crisis rather than the emergency, if I may put it in this way, (206) can be resolved in less period than that. I don't know how to assess almost sight unseen whether the intervention of a Court in sort of stage 1 (A) would be hurtful. I suspect it would and to demonstrate how difficult this would be, I will give you the following example.

In our clinic, we will not automatically have the doctor see the child and the parents together, because we think we need to assess whether that would be a helpful maneuver for the child and the parents.

In other words, somebody will see the parents and somebody will see the child and then we will decide, is it helpful.

Now, I don't know, sight unseen, how you can possibly know whether it will be helpful to the child to be seen in this way, because I think the assessment is inordinately difficult anyway. I think the assessment of need which I believe ought to be the criteria for admitting adolescents and children takes an enormous amount of sophistication and takes a great deal of observation and I don't know how a Court could do this.

The other thing is, something like this, one of the problems that adolescents have who are disturbed is their terrible disappointment in people. You know, disturbed adolescents have tried to make relationships with grown-ups and have failed either because of them (207) or the grown-up. If you really want to know a boy or girl and this is common sense, I think, you have got to get them to feel that you are their friend, you are on their side. These sorts of feelings are obvious.

Now, if it is bad enough that the doctor who assessed the boy or girl has done this and disappointed them by, in a sense, abandonning them when they send them on to somebody else, if the child is to be assessed in a Court, it seems to me somebody has got to make relationship with the child to try and make an assessment as to ought they or ought they not.

My concern is that it is a tease for the boy or girl. For example, one of the things that happen in our unit is that young lawyers come to work with the kids who want out and in working with the kids who want out, the kids begin to see the young lawyers as their friends, which is perfectly reasonable and proper and as it should be. The case goes to Court, however, and as far as the young lawyer is concerned, that's it. He is off somewhere else. So even that procedure can be hurtful, so I would be concerned about it being hurtful to the boy or girl. I'd be concerned about it in evaluating the family and although I agree that psychiatrists aren't often seen by children as being helpful, I don't know that the Courts are seen as helpful by children, (208) quite frankly.

Q. Doctor, in connection with that last question, one point I was trying to question you about—

MR. FERLEGER: Objection.

JUDGE GIBBONS: Let him ask the question.

MR. FERLEGER: I was objecting to his explaining what he was trying to question him about. It seems to me it is leading.

MR. ROTH: I will strike that.

Q. How do you value—let me put it this way: How does the child value a family?

A. The child values a family first of all if they value themselves.

Parents who see themselves as good people and as good parents are in fact likely to be valued by their children, which I guess is reassuring. Families, however, also need to be valued by society. It is painful to children, indeed, when society does something to their parents; sometime the parents precipitate it, but then society does something which the child sees as a devaluation of the parent. One of the things society has been careful to do, I think, even though sometimes society has sometimes to punish parents as people in society, they don't generally devalue the parental role unless they see the parents behaving in a way which society (209) sees as hurtful to the child.

Very specifically, society only interferes in family structure, and I believe this is right, when it sees parents doing something which society says, "You cannot do this because you are hurting your child."

I think likely for that to happen, society, you know, as shown by the Courts, tends to demand very sophisticated proof this is so. In Michigan, the law is that if we see a child who we think the parents are abusing we are obligated to tell protective services and if they think we are justified in being concerned will then go to the Juvenile Court and ask for a guardian ad litem to be appointed. I believe quite rightly, the law is quite sensitive about this.

They don't generally cut into family structure.

Q. What type of interference do you think would occur if the hearing occurred for a juvenile prior to admission where the parent is in conflict with the juvenile or the child?

A. It would seem to me that what would be happening would be that a child's statement which I have tried to point out is inevitable, that "I don't want to," is going to be taken by the Courts, I think, and I am not—I think—I am talking about the parents, as meaning the Courts (210) are going to adjudge their worth as parents.

It seems to me there is very little difference in some ways between my child of 14 saying to me, and perhaps I say this because I am a psychiatrist and I don't think being in treatment is that awful, but if my child of 14 says to me, "I don't want to go to this school," it seems to me my role as a parent is to say, "If I believe that it is the right school, you should go to this school," and frankly, if society then wanted to cut in, assuming it was a good school and recognized by the educational authorities, cut in and allow my child, as it were, to hold my parent-ing up, over that sort of issue, it seems to me we are in a very interesting ball park.

Now, I get the feeling that something similar is in this hearing. It seems to me the parents have to make a judgment about the statement of their dependent children. If they are not capable of making that judgment, that seems to me to be a very sophisticated assessment and as I would see it, this is under the guise of the issue of institutionalization; very real questions are being raised about the value of parenthood and I must take a point that if a parent says, "You must go to a hospital," and hopefully, the psychiatrists who have seen the child are competent and everybody is competent and they tend to be I think in this state as in ours, and the (211) Court said, "No," I believe the Court has a tiger by the tail, because the Court in fact has then said loudly and publicly, "You do not have to listen to your parents."

Now, once you are over the age of 15, parents can no longer—I use that in terms of the end of puberty—parents can't control you by force. You know, frankly, a pubertal 15 year old is likely to be bigger than his father and if you wish to control him, you sure as heck can't do it by force. You can do it hopefully because you are respected by the child. Hopefully, 15, 16, 17 year olds will do what we say, because they respect us.

Now, if our children are told, "You don't have to do what your parents say," then we have put them in the situation, I believe, in this very complicated society, where I would remind you that 42 million people move a year, which means they may have no one else in their lives, but their parents; we have put them in the situation of taking anybody away whose opinion they can value and I think that is a very dangerous thing to do.

Q. Doctor, in Pennsylvania, the hearing is provided subsequent to admission for juveniles age 13 to 18, who object—

A. Yes.

Q. —Do you feel that procedure would be harmful to a juvenile?

(212) A. No, providing, as I would hope, that the institutions and the lawyers work responsibly together.

The implications of that statute is lawyers ought to understand something about psychological illness. Psychiatrists ought to understand something about the law, if I may put it this way. I think it is very important that the child does not, as it were, catch an adversary relationship between the lawyer and the treating people, because they will divide and rule, which is not always helpful to youngsters.

I suppose I shouldn't throw in gratuitous comments, but I guess I have the feeling if the law really takes more responsibility for saying a child must stay in a hospital, then, it seems to me, the law will have to take more responsibility for the quality of caring for patients in hospitals.

And, quite frankly, I'd like to see more responsibility taken by society for the quality of care in most hospitals.

I must make a point. I am not against the law intervening in the quality of treatment. I am not against the law supporting a child that is needing to be in treatment, but what I am against is the sort of timing that is being thought of here which I can see only as enormously destructive and not at all helpful.

(213) There is one other issue. We have to be very careful not to label children. One of the things that made me a little unhappy with your law, if I may say it, is you have something called voluntary commitment. If I understood it right and I may not have, because I am not a lawyer, it means that there are certain situations in which you voluntarily accept the label of being mentally ill; am I right about this?

If that is the case, then I think it is deplorable that children should be labeled. One of the responsibilities I would see the Court as having is when they tell children they need treatment, which they may tell them, they should not stick a label on them, saying, "You are crazy," because one of the problems children have if they are mentally or emotionally upset is they don't know who they are and they are all too willing to adopt the label we give them and so if we label them delinquent, they become that way; and if we label them under-achievers, they become that

way; and if we label them crazy, they become crazy; and the responsibility of a hospital is to provide facilities that don't add to the self-labeling quality.

Q. Doctor, do you feel juveniles should be permitted to release themselves and admit themselves as adults, under 402 and 403?

(214) A. No.

Q. Why not?

A. I have no objection to a juvenile admitting himself, providing that in so doing, they are not getting the institution to act against their parents.

You see, there is a very interesting—you know, disturbed youngsters who are trying to assess the value of their parents, play a sort of fascinating maneuver. They will try in all sorts of ways to get people to agree in action, that their parents are no good. So, if say, a 16 year old who is not an emancipated minor, that is to say, he has contact with his parents, lives with them, presents himself for treatment in our hospital, whether it's in-patient or out-patient, we will see the boy or girl once; we will not see them more than once, because we believe that in so doing, we are implicitly agreeing that their parents are not good people and we are not prepared to agree to this.

So, we will not admit an adolescent who is not an emancipated minor, which a different category, who is not suffering from venereal disease which is a different category in our state and which is not drug indicated and excluding those, we will not admit an adolescent under any circumstance without the agreement of his parents and I might add, because of the peculiar financing of the (215) Department of Psychiatry of the University of Michigan, this is not primarily a money issue, because in our state, if the parents can't pay or if the insurance carriers cannot

or will not, we have a state appropriation that picks up the bill. So, it is not an issue of money.

Q. Doctor, there's been some indication that if a child needs help, that under Pennsylvania law, if it is an emergency, he ought to undergo an emergency commitment.

Now, my question to you is:

What kind of crises do you find juveniles—do you find juveniles are relating to when you first see them; are they emergency crises as being dangerous to self or others?

A. Sometimes, they are crises in a sense. Take a boy we got admitted the other day. He had shot himself somewhere in the thumb, had been admitted to the local hospital, alleging that he had been shot by an intruder. The local surgeon was really quite clever and decided that that sort of thumb shot wound could not have possibly been done by somebody else and he was sent down to our emergency room and he was admitted.

On the spot we got a history of five suicidal attempts from him over the year and he still said he didn't want in. What happened was he said he didn't want in and we say, "Of course, you are to come in."

(216) We have never had ever to drag a child into our hospital. The interesting thing is they say they won't, you bow to the fact that they won't and then they come in as you would expect. That is a typical crisis. Typical crisis which causes trouble or emergency that causes trouble is when adolescents have behaved in a way which is acutely murderous, which is regrettably not unusual and that is troublesome because if an adolescent has been violently assaultive in their behavior and then they frighten

people and they come in with a fear around them which tends to be terribly disrupting to adolescent wards, so that is another sort of case, however we might take it.

We won't take for example, youngsters who have murdered somebody, because we don't have the sort of facility that can protect them or society. I should say youngsters who committed homocide. I think I am being technical. Otherwise, we will take youngsters who have physical illnesses, who abuse their own physical illnesses; diabetics who get out of control, epileptics who won't take their medication. We take youngsters who behave with direction in a way which is destructive to them.

We take youngsters who repeatedly run away from home and put themselves in danger by exposing themselves to who knows what and so on.

(217) Admission is always a crisis, you know, because even if everybody said, "We want you to come in," at that moment in time, it is a painful crisis.

Q. Doctor, you indicated in your answer before, that there was a labeling process, as you understand the law to be?

A. Yes.

Q. I question what effect would a prior hearing have had on a youngster in relationship to a labeling process?

A. Well, I think it would give them a very false sense of their own psychological state in a whole variety of ways. If they are labeled so ill that the law says, "You must go to a hospital," I could only leave this to, I think, the imagination of the Court as to the message this is giving.

Heaven help the child if the law says, "You are solemnly—," I don't suppose it would happen, —"Under Section so and so of this Act you ought to be in the hospital," because that means the youngster gets a strange specialness which will not be helpful.

I think the two things to worry about are false labels and crushing children, and of the two, I don't know which I'd be concerned about most. The thing to worry about insofar as the family is concerned is undercutting their roles as parents.

(218) Q. Doctor, if the hearing were held before admission and the juvenile were present, hearing all the symptoms that may require, if you will, his admission, how do you think that would affect the juvenile—how do you feel it would affect the juvenile?

A. One of the important aspects of growing up is privacy. Everybody in this room who has been an adolescent and we all have, or who have adolescent children of their own, know perfectly well that a very important thing for them is to be emotionally private from their parent sometimes. Adolescents do not tell us everything. One of the things that adolescents have to do when they go into treatment is, to some extent, they have to abandon this privacy. They have to let grown-ups in on their private world which normally they don't do.

Normally they keep a great deal of it to themselves. I believe this is a very special responsibility, quite frankly. I believe we should not over-pressure adolescents to tell us too much, too fast, because that's assaultive.

I believe we should have much respect for that private statement, because that seems to me to be important, too. In those cases in which for example, it has been necessary

when a child wanted to go before the Juvenile Court, if we had wanted to say something that (219) the child has said, which he might not want his parents to know, for example, we ask permission and do sort of approach the Court, tell the judge what the child has said with the child's permission and this may be going to happen. There is a real issue of protecting privacy.

The problem is, you know, that adolescents who are psychologically ill are very easily persecuted and they very easily feel the world is attacking and you have to tread on eggshells not to do things they feel would be attacking. Appearing in Court is a very sophisticated business, I would tend to think, particularly if the child is there.

Q. Doctor, do you feel that the age of 18 is satisfactory in limiting a parent or do you feel that that age should be increased or lowered for the juvenile to be able to admit themselves?

A. I never thought when I was a young man that one day I would be thought of as conservative, reactionary and those sort of words.

One of the most deplorative maneuvers Western society pulled was to move the legal age of adulthood back to 18 from 21. Adolescent-like aging is a time of life of transition and a time of life where you cannot fit where people are psychological to chronological age.

Twenty-one was an excellent age of adulthood, (220) because by then, most people have reached physiological and thereafter psychological maturity. By 18, most people—I won't say most people—a significant number of people are still showing signs of immaturity, because for example, they were late developers into puberty. Some people become pubertal at 11 and a whole series of psy-

chological changes take place. Some people don't become pubertal until 16. Very tall people do not become pubertal until they are 16, very often.

People who arrive at puberty at 16 need three or four years to catch up to themselves, and the legal age limit of 18 causes complications for those adolescents who are late maturers. And, unfortunately, it invited middle adolescents to become choleric. One knows they identify with behavior of older adolescents and older adolescents are now in our state allowed to go into bars and this means to 15 year olds that they ought to go into bars and barmen can't tell the difference, and they can receive a fake identity card.

It is a mess, but it's been done.

Q. Are there hearings given in Michigan prior to admission of a juvenile?

A. Only if the juvenile has broken the law and is going to go to a hospital via the Courts. That is, there are some juveniles who have broken the law and may be sent (221) to us or any other psychiatric hospital by the Juvenile Court when it's been established that they have broken the law and the defendants—it is usually the defendants that request hospitalization, and they can be sent by the Court. They are not committed, usually in a formal sense. The Court merely says, you know, "You ought to go be treated in this hospital," and that's done in the Juvenile Court.

Sometimes adolescents who are waived to the adult courts—I don't know whether this procedure takes place in Pennsylvania, it does in Michigan—a 15, 16 year old can be waived to the adult court, depending on the severity of their crime and they may be ordered to the hospital and

be legally committed to a hospital. Those are about the only adolescents in the state of Michigan who are committed because, our law is different to yours and so commitment as such is very rare there.

Q. What happens if a parent wishes to admit his or her child into your institution, and assuming all prior safeguards are met and the juvenile objects, when is the hearing provided?

A. The point I will make is, almost all of the juveniles object in words prior to being admitted. They don't object in action, and then, what happens is, that usually when they get admitted, they are—initial objection tends (222) to go or they do a very interesting thing. They go on saying, "I don't want to be here," but they go on acting as if they do want to be here, which we expect.

For example, I saw a girl the other day who was 15, who I suppose was the most abusive—colorfully abusive child I have seen in a long time, and she was colorfully abuse in the most amusing language and told me in some 50 minutes how she had no intentions of staying in my blankety-blank-blank hospital, and she would run away and she wanted a lawyer and so forth. We proceeded to get her a lawyer who arrived about three days later. When the lawyer came, she said she didn't want him. She left my office; she went from my office to the hospital school. So all the shouting of, "I don't want to," was verbal and not behavioral and that is common.

Q. But, Doctor, after the child has been in the institution, is there any mechanism in Michigan for providing him or her with a hearing?

A. Oh, yes, the child says, "I don't want to be here." We are then obligated to get the child an attorney

which we proceed to do. We have a number of attorneys floating in and then being told by the children they don't want to see them, which is another maneuver they can pull.

After all, you can disturb the law as well as disturb everybody else. But they get their attorney, (223) the attorney comes and explains their rights to them and so on and so forth.

Q. And, what age does that apply from?

A. Thirteen. The law in Michigan is 13 on up and they must be provided an attorney within seven days and you may exclude Saturday and Sunday, I believe—but they must get the attorney within a seven-day period.

Q. In general, then, you are familiar with there being a hearing afterwards?

A. Oh, yes.

Q. When a juvenile objects after he's been admitted, is there any attempt by the institution to coerce him or to provide punishment, rather than provide him with an attorney?

A. I suppose, I would love to be able to say nobody in our institution is ever punitive because punishment is terribly sterile for adolescents, I would think, unless it's applied by people who they perhaps really know love them and they don't really know we love them so we don't punish.

Punishment does not apply as far as we are concerned. I mean I can't guarantee that there is not some member of our staff who has got in under the wire who behaves as they shouldn't behave.

In a general way, I would think punishment (224) was not an appropriate word in our facility, frankly.

Q. Doctor, one last question; it has been alleged that juveniles are in institutions as mentally ill when their actions may only be defined as juvenile delinquency.

A. Sorry.

Q. It's been stated that juveniles are in institutions, because they are supposedly mentally ill when their actions would only be those of juvenile deliquents. They would be considered delinquents.

Would you please comment upon that?

A. As you know, juvenile delinquency is socially defined. You become one when the law says you are, and whether the law says you are will depend on your social class, the ethnic class.

One of the problems is that, typically, adolescents who are in pain show their pain by inflicting pain. That is to say, typically, an adolescent asks for assistance for himself or herself by behaving in a way which society would perceive as painful, so to some extent in that they arbitrarily inflict pain on others to meet their own needs.

Really, all adolescent illness is antisocial, if I may use that phrase instead of juvenile delinquent. It is almost inconceivable for an adolescent to be psychologically disturbed without hurting someone, (225) either his parents, his teachers or himself, if by no other reason, but making them helpless and useless and this is one of the things that adolescents do.

Adolescents get great gratification unfortunately, particularly when they themselves feel helpless. They get a lot of gratification from stirring up people in their environment and one knows this very well. This is not very helpful to them ultimately in helping them. If he requires

psychological treatment, it is more complicated because sometimes clever juvenile delinquents are so terribly successful. It is very difficult to convince a 15 year old and I saw one the other day, who successfully made $24,000 by stealing IBM machines from a variety of offices and then selling them. It is very difficult to convince him that this is an unsatisfactory way of living.

His attitude was, "Don't tell me that crime doesn't pay; it does." He was not very motivated to have anything done. So, to that extent, successful delinquency complicates treatment.

MR. ROTH: I have no further questions.

JUDGE GIBBONS: We will take a five minute recess.

(Whereupon, a recess was taken.)

JUDGE GIBBONS: Back on the record.

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(226) *Cross-Examination*

BY MR. FERLEGER:

Q. Dr. Miller, from your Curriculum Vitae, I notice last year you published an article called, "The Effects of Social Prejudice on Hospitalized Patients."

Now is it your opinion that social prejudice more adversely affects hospitalized patients as opposed to mental patients on an out-patient basis?

A. The article actually was really not about that at all. It was discussing the Eagleton affair and it was discussing the relationship between the behavior of groups of adolescents on a ward and their knowledge of the Eagleton affair, if I can call it that, and the prejudice actually against being a psychiatric patient.

It wasn't the issue of an in-patient or an out-patient. It was frankly, the issue of being aware of the prejudice.

Q. We can agree that there is a tremendous amount of prejudice in our society in being a psychiatric patient.

A. I would have thought still.

Q. Dr. Miller, you testified with regard to adolescents that the need to say no is a rather healthy need because they desire to be healthy or some part of them wants to be recognized as healthy. The same process occurs in adults, isn't that correct?

(227) A. Yes, but I am not sure it is quite the same.

You see, an adult who says no is presumably saying no, one would hope, only out of the conviction that the reality with which he is being presented is demanding a negation. An adolescent says no because a main motive is to say, "I am myself."

I don't think that's a primary motive with adults. I would hope not.

Q. But it is also a motive even—

A. I would hate to generalize about the adult population. I can conceive that some adults would need to say no, because of some inner psychological reason, but I couldn't possibly generalize about everyone.

Q. But, you would make that generalization about juveniles, though?

A. Oh, yes.

Q. But not about adults?

A. That's right. One is in the area that I work in and the other is an area in which I work less.

Q. Doctor, you testified that for the majesty of the law to sit on a child and say, "You have to go into the hospital," would not be proper.

Now, the current state of the law which does tell the child, "The law requires that you must go in;" isn't that also sitting on the child?

(228) A. The point I'm trying to make, it was depending on how it is done and when it is done and who the child is perceiving as helpful and supportive and so on. It is a multi-determined situation.

Q. It's possible then that there could be a situation if the Court was as creative as it might be where we might develope a procedure where the child would see the process as a friendly one rather than as a surrogate one?

A. Social change is always terribly difficult and I would hate to express an opinion about that sort of social change.

Q. Doctor, you testified that the age of 18 is acceptable, though you regret that we have retreated from the age of 21.

Now there is pending in the Pennsylvania legislature and I am sure you have not seen it but it is an attachment to Mr. Roth's documents that will allow children 14 and up to admit themselves into mental hospitals.

Would you agree with that bill and support that proposal?

A. I find it extraordinary. I haven't seen the bill and I find it generally extraordinary that a society which prided itself in its increasing civilization by protecting its children more and more with things like child labor laws and the like should in these subtle and (229) insidious ways as I see it, turn the clock back. It's very remarkable.

Q. Now, you may be aware—are you familiar with Dr. Masterson's book, Teaching and Learning Adolescent Psychiatry?

A. You put me in a terrible spot. I have looked at it, yes.

Q. In his preface he notes with approval that in Georgia, the law now allows teenagers to get psychotherapy on their own volition.

Would you support the law and allow teenagers, however you define them, to get treatment on their own?

A. In the last part of your sentence is the issue.

The issue is, what do you mean by teenagers? I would make the point that if an adolescent is emancipated from his parents, then I would feel quite strongly he ought to be able to seek psychotherapy on his own.

Q. Unemancipated teenagers should not be allowed?

A. I think you are getting into very interesting technical areas.

I might or might not disagree with Mr. Masterson. It is my belief that we as doctors should not behave in a way that the child—that a child could see as taking his parents' role.

(230) The problem is that if a boy or girl comes for therapy and says, "I need therapy. I want it, but my beastly parents . . ." et cetera, et cetera et cetera, when one knows the child is seeing the parent as beastly but they may not be at all.

One of the great difficulties in this whole area is that if you do see a youngster without the parents' knowledge,

it seems to me, professionally, this does not go well. In Britain, there is no problem of patient—

Q. Excuse me, I was not talking about without the parents' knowledge.

The question is whether or not the parent consents; not to do it secretly, but to do it simply with the child applying.

A. I can see no problem if the parent of a child of 17, 18, or 19, says no, because by 17, 18, or 19, depending on the psychology of the child, the psychology of the parent, it might make sense to go along with that.

My general experience is it does not. I generally feel that parents when they say no, are themselves saying, "Please explain to me what this is all about," and so on and so forth.

Q. Doctor, you testified that a full and open hearing with a child listening to possibly private things, could be detrimental.

(231) Do you think that that problem could be cured simply by having some of the testimony heard in the presence of the child's lawyer, but with the child absent?

A. I suppose this is the area of the issue of the child's confidentiality and the keeping of the confidences and so on and this is terribly complicated.

If a boy or girl has only chosen to tell his lawyer certain things, then, it seems to me that the lawyer is entitled or should assume he's been told it all.

Now, I have had a case and situation which I know perfectly well the lawyer has not been told it all. I would not see it as my responsibility to tell the child's lawyer what all of it is.

Q. Can you answer my question which is whether or not a Court could adopt a procedure which might make it less traumatic or not traumatic for there to be a hearing by taking some of the testimony—

A. We seem to be back in the social change area.

Theoretically a Court can do all sorts of things.

Q. You don't feel you are qualified in that social change area?

A. I have done quite a lot of work in social change. I know how terribly complicated it is.

Q. Doctor, you are aware, I'm sure, that in the juvenile (232) delinquency area, some of the reasons they are categorized as that is because they are incorrigible and do not obey parents and they can petition the Juvenile Courts to get the children to obey and if the parents bring such a petition and the Court says the child was not being disobedient to the extent the Court would get involved, isn't that sort of a situation where the Court would be infringing upon the parents' right to demand obedience from children?

A. Yes, and most responsible Juvenile Courts feel this way strongly and if they get into this situation, one of the things they surely do and good Juvenile Courts have attached to them, many social workers, professional assistants and so on, and I think they commonly see this petition—perhaps "commonly" is wrong; I don't know enough—but it is not within my experience for a good juvenile judge if this petition is before him to see this as the representation of a family crisis. Although he may dismiss the petition he may instruct his Court social workers to try and help resolve the family crisis.

Q. I asked if that could not be perceived as the rejection of their proper parenting role—the parents?

A. I am less anxious about the parents' feeling that their role is being rejected than their child seeing that their role is being institutionally devalued. I think they are quite different.

(233) Q. If the Court said to the parent, no, petition denied, couldn't that result in the child's feeling that the parents—you know, "You parents blew it."?

A. I think that is an inevitable conclusion one would reach and I think it would be a sad situation if, frankly, applying the law in an arbitrary fashion, a judge was to say this, not knowing what family disruption he may cause thereafter.

Q. Doctor, you would not want to end the practice of holding hearings for accused juvenile delinquents, would you?

A. Most certainly not. I think they have every right to have a proper hearing as to whether they are guilty of the behavior of which they are charged or whether they are not.

Q. That would be true even—

MR. ROTH: I have noticed on a few occasions the Doctor has attempted to continue with an answer and he has been interrupted.

JUDGE GIBBONS: Would you finish your answer.

THE WITNESS: Yes.

Q. That would be true whether or not the juvenile delinquent had an emotional disturbance?

A. Since a large number of crimes that are committed by juveniles of emotional disturbances, I suppose society (234) says that they must be adjudged in the Juvenile Court.

If I inflict pain on society as a youngster to which society takes such exception to label a crime, then it seems to me that there is a price that's asked and society has to adjudge whether or not I committed the crimes and I believe they should do that.

Q. Now, Doctor, I appreciate very much your comments earlier on the question of timing of this due process and protections for children.

I would like to describe for you just very briefly a proposal that Pennsylvania's Association of Retarded Citizens has made to the Court and see if you would feel that this sort of timing is—

JUDGE GIBBONS: You mean this Court?

MR. FERLEGER: Before this Court.

JUDGE GIBBONS: Would you refer to an Exhibit number so someone in the future would be able to know what you are talking about?

MR. FERLEGER: For the record, I am referring to a document which was docketed this past Friday. I don't have the docket entry number which is titled, "Brief of Amicus Curiae Pennsylvania Association for Retarded Citizens, Incorporated, and National Center for Law and the Handicapped"—

JUDGE GIBBONS: Show the witness that (235) document.

MR. ROTH: Your Honor, I would have to object. I do not have a copy of that. Where are you referring to?

JUDGE GIBBONS: What page is that?

MR. FERLEGER: Page 39 and the next page or two.

Q. It would be just as satisfactory to me, Dr. Miller, if it pleases the Court, that I can just summarize a procedure and see what you think of it.

A. May I mark this copy?

Q. Certainly.

MR. ROTH: Your Honor, I am going to have to object. It seems to me that the issue at hand is whether or not a hearing should be provided prior to the admission of a juvenile and not whether or not this Court should have the function of determining what type of procedure ought to occur, other than recommending a due process hearing or not.

JUDGE GIBBONS: Overruled.

A. I must say, I am most unhappy really about expressing off-the-cuff opinions about something that people really thought out and I am rather distressed to say, "Yes, it looks fine," or "No, it does not look fine."

Q. I am not asking you to do that.

(236) Let me ask you a question, Dr. Miller, with regard to that. That procedure, to paraphrase it, involves having the juvenile and the parent get together with a review board at an institution to discuss the proposed plan of children. The juvenile will be very assured that this is a very serious thing and there will be an atttempt to work out something that is acceptable to the juvenile, his or her attorney and the parents, for a voluntary commitment to be signed by the parents.

This will be an informal hearing, not before the Court, you know, with relatively little formality. Only

if nothing can be worked out in that administrative hearing, will there be a judicial hearing, if the child or the parents objects.

Do you think that such a procedure which avoids, it seems to me, some of your objections about the Court being involved, would be acceptable to you?

A. Do I understand that what would happen is the child would have been admitted to the hospital and he would have been in the hospital for some time and the hospital staff would have worked out a treatment program which seemed to be appropriate for the child's needs—

Q. No, it would be prior to hospitalization.

A. That's impossible.

You cannot work out a program for a child (237) like this prior to hospitalization. It's a naive idea.

We have a hospital school. Children come to us and I guess I have many negative feelings about the American high school system. Children come to us from high schools with statements, for example, that they have failed completely in everything and the note that we will get from the school will tell us absolutely nothing about that child's attention span, ability to be cognizant, ability to achieve imaginatively, et cetera.

Until we placed that child in our school setting and assessed that child's ability, we are completely unable to say what sort of school program the child should have.

Q. If you have a procedure that Pennsylvania law allows for out-patient evaluation, which could take a few weeks, would that improve your opinion as to the feasibility of this proposal?

A. You see, if the circumstance were such that the child was willing to come, that the family situation was not one of maximum—was not stressful, than in a general way, I would imagine that you would prefer out-patient treatment anyway.

You only send a child into a hospital when the stress in the family or the child's inability to contain anxiety is so little that in fact the child won't (238) come, or for example, the child physically cannot because of distances. So, if out-patient assessment is possible, it may well be that in-patient treatment is not necessary. It may be, but it may not be, but I thought we were talking about youngsters who needed to be in hospitals.

This is my unhappiness about this because I have a feeling we can spend a long time at looking at what you mean.

Q. Just to be clear, we are talking about assessing the need and figuring out whether or not someone needs to be hospitalized.

The question is how is it determined whether or not he has to be hospitalized?

A. This is talking about agreeing to a treatment plan, isn't it?

Q. Yes.

A. And I, by the way, very much believe that parents should be told of the treatment plan, should be involved in it, should understand it, et cetera.

Q. Do you feel at the time of admission, there ought to be or after an evaluation, of course, that there ought to be a work-up of the proposed treatment?

A. Treatment plan is not a rigid thing. Treatment plans vary very much on the state of the child. I guess I

am unhappy about answering your question, because it (239) seems to me that there are so many ifs and buts around it, that I feel I am not saying anything constructive.

Q. Let's get on to something else, then, Dr. Miller.

You, in your book, Growth to Freedom, the Psychosocial Treatment of Delinquent Youth, you discussed a residentiai program for offenders or delinquent youths, and in working out this adventurous program of a non-institutional care for delinquents, you discussed the negative effects of institutionalization.

A. Yes, I have great concern about the negative effects of institutionalization.

Q. You spoke about correctional systems and the systems in England, et cetera; is that right?

A. That's right.

Q. You stated, "People who have been institutionalized, that that process tends to produce what has been called an emotional deficiency disease;" is that right?

A. That's right. By the way, I must explain something.

Institutionalization in that sense is being used technically. That is to say, in theory, you become institutionalized, I believe in social terms, if you are merely placing someone in an institution. In a sense you are institutionalizing them. That's not the sense in which this is being used.

Q. I understand. You mean by "institutionalization," (240) the total institution that Goverman described, or the kinds of places that we call mental hospitals and juvenile institutions; is that right?

A. In general.

Q. Without talking about institutions like this Court; is that right?

A. No, I think not.

It may institutionalize us eventually, but—

MR. FERLEGER: No further questions, your Honors.

JUDGE BRODERICK: I would just like to ask one question, Doctor.

I wonder if you had an opinion as to whether some type of a preadmission hearing would tend to encourage or discourage parents from seeking psychiatric help for their children? Had you thought about that?

THE WITNESS: I had not honestly thought about it very much, your Honor. It is terribly hard to say.

In general, parents are understandably, most parents are very reluctant to seek hospitalization for their children—psychiatric hospitalization. They do almost anything to avoid it.

I think in lower socio-economic classes (241) parents do tend to have a conviction of the Court as being hostile, because I think that can be in the culture. I think they find it harder. I think middle class parents who may know a judge who lives next door and have a quite different acquaintanceship with the law, it may not make any difference.

I tend to think the poor and ethnic minorities who are often very paranoid about the law might find it hard.

JUDGE BRODERICK: I have no further questions.

JUDGE GIBBONS: Thank you, Doctor.

(Witness leaves the stand.)

JUDGE GIBBONS: Call your next witness, please.

MR. ROTH: I'd like to call Dr. James Masterson, please.

JAMES F. MASTERSON, sworn.

THE CLERK: Would you state your name in full?

THE WITNESS: James F. Masterson.

Direct Examination

BY MR. ROTH:

Q. What is your profession, Doctor?

A. Psychiatrist.

Q. Are you licensed to practice medicine and psychiatry?

A. Yes.

(242) Q. Where are you licensed?

A. New York State.

Q. From what medical school did you graduate?

A. Jefferson Medical College, Philadelphia.

Q. Where did you intern and for what length of time?

A. Philadelphia General Hospital for one year.

Q. Where did you perform your residency?

A. The Payne-Whitney Division of the New York Hospital, Cornell Medical Center, New York.

Q. What is your medical specialty in psychiatry?

A. Adolescents.

Q. What do you feel qualifies you as an expert in that field?

A. The time I interned, my training in adolescent psychiatry which was in about 1956, unlike child psychiatry and adult psychiatry, at that time in the development of this specialty, there were no places to be trained as an adolescent psychiatrist; in that sense I did not have a formal training, but I was taught by the best teachers, the adolescent patients. I started a clinic in 1957, an outpatient clinic and started doing research and over the years I have continued that and have contributed a good deal to the literature and text books.

Q. Are you a diplomat of any Board of Psychiatry?

A. American Board of Psychiatry and Neurology.

(243) Q. Do you currently belong to any professional groups?

A. Well, lots of them.

Q. Have you ever taught psychiatry?

A. I have been teaching it since 1956.

Q. What brand of psychiatry do you teach?

A. Mostly adolescent psychiatry.

Q. Where do you teach it?

A. At the Cornell Medical Center since I finished my residency there in 1956, and since '68, I have been in charge of a program for the treatment of adolescents and the teaching of psychiatric residents adolescent psychiatry.

Q. Have you offered any psychiatric articles or published any books?

A. Yes, both.

Q. Are these articles and books related to adolescent psychiatry?

A. Yes.

MR. ROTH: Your Honors, at this time, I would like to introduce as defendants' Exhibit 12, the Curriculum Vitae of Dr. James Masterson.

MR. FERLEGER: No objection.

JUDGE GIBBONS: It may be admitted.

(Whereupon, the Curriculum Vitae of Dr. Masterson was marked defendants' Exhibit 12, in evidence (244) as of this date.)

Continued Direct Examination

BY MR. ROTH:

Q. Doctor, have you ever been associated with an institution?

A. The medical center in which I work, in the sense of a psychiatric hospital; I have been associated with them since 1952.

Q. What hospital is that?

A. The New York Hospital.

Q. Do you recommend hospitalization of juveniles?

A. Yes.

Q. Do you admit juveniles?

A. Well, as the head of the program, of the inpatient program, I am in charge and pass on all patients who are admitted and all who are rejected for admission.

So, I do it all the time.

Q. Doctor, would you please explain to us, when a patient comes to you with his parent, what you look for from the standpoint of the patient, the parent and your own role?

A. When the patient comes, we see him as coming —the adolescent as being the patient and coming to us for an evaluation. Our function is to try to evaluate this problem in the adolescent and come to a decision as to what is the best treatment for him.

In the course of this, we examine the (245) parents and get their reports as to the behavior, examine the adolescent and take whatever other reports are sent in from schools or social agencies and through the process of examination, often will confront and challenge some of the evidence that is brought in by the family and try to come to some decisions as to what is wrong and what has to be done about it.

This may or may not require hospitalization. If we think—Dr. Miller has already indicated some of this—if we think, you know, let's say at the most urgent he is a danger to himself or others, then he will be hospitalized. If he cannot function in the environment, cannot maintain himself in school or manage his relationships with his peers or parents and just cannot function, he will be hospitalized or if perhaps he is suffering from the difficulty of controlling impulses to such an extent that he's gotten himself into all kinds of behavior problems, we will hospitalize him.

In general, hospitalization is probably the last alternative used. First you would think of out-patient treatment and other forms of care and then, if these are not appropriate or do not work, you think of hospitalization.

Q. Doctor, from your experience, do you discover that parents take alternative measures before hospitalizing (246) their children?

A. In general, for the most part, they are very reluctant to hospitalize them for lots of reasons. Part of their reasoning having to do with the interaction between the parents and adolescent.

Whatever function that the adolescent performs in the family system is interrupted when the adolescent goes into the hospital and this creates difficulty for the parents and for this reason, among others, they don't want to hospitalize them and try some other method first.

Q. Do you practice adult psychiatry?

A. I see adults in my private practice.

Q. What are the psychological differences between the normal adult and the normal adolescent?

A. Well, simply stated, the adolescent is in a state of incomplete development and the process of adolescence is one, a process whereby he masters certain tasks, and in the course of that, becomes fully developed and becomes an adult and just to summarize it briefly, the areas in which he does this is, first of all, the area of emancipation, where he emancipates from the family and this really involves two fundamental parameters.

One is, he goes from becoming emotionally dependent on a mother and father to being independent (247) and in the course of this, his values or standards or conscience changes from being more or less a repetition of his mother and father to being an amalgamation of that and other influences that he has had on his own. So, he becomes a new structure and as part and parcel he learns to adopt a heterosexual role and to find a kind of career in life and

all of these, as he tries and experiments, contribute to a sense of his own independent identity which is unique to him and different from everybody else.

In the course of this process, where he has to experiment and try, he is able to cope maybe better at some times than others because of his capacity and environmental demands which go back and forth. At this time one of the key contributors to this successful development, is the function of his parents.

In other words, I think the parents provide a vital, emotional function for the emotional equilibrium of the adolescent at this time for the process of emancipation and becoming independent and they perform this through, in general, stepping in at times when he is not managing with guidance or with control.

Q. Doctor, how does an emotionally disturbed adolescent differ from an emotionally disturbed adult?

A. One of the things that concerns me about this proposed change is that, as different as the adolescent—(248) normal adolescent is from the normal adult, the difference between the emotionally ill adolescent and adult is much, much greater. The reason being and I think this is a common error that everybody makes, because they are chronologically and physically adult, the assumption is made—the assumption is made they are chronologically adolescent, particularly those who come to the point where hospitalization is necessary.

These adolescents are not emotionally adolescent, they are infants. Their emotional development is infantile. Although they are six-foot-four and weigh 250 pounds, emotionally they are two or three years old, and

now, what does this mean in terms of their behavior and their observation? It means that when it comes to their management of themselves, the way they execute their own emotions and deal with their life stresses, it is dominated by a poor impulse control, poor frustration control, poor judgment.

These are all manifested in an inability to do what is essential for an adult and that is to select and choose among those impulses that they are bombarded with—which one they will express—depending on the gratification they may get and depending on the harmful effects if they do. They are left to the anarchy of their impulses. They cannot do this. When the impulse arrives, (249) it must be discharged regardless of the cost. So that, as I see it, in this suit, in which you are taking, as I see it, the authority away from the parent and handing it to the adolescent, you are giving this particular adolescent his civil rights at the cost of his human rights, I think.

His human rights being the right to the developmental influences necessary for his own development, and giving him this choice, it seems to me, must be based on the assumption that he has the capacity to exercise it in his own best interests.

If he had that capacity, I don't think he would be going into the hospital. He does not have that capacity and so, to give him a choice, I think does him a disservice by misperceiving what his basic emotional needs are and treating him as something he is not.

We have a word for it which is kind of fancy. We call it "adult Aphroditing the adolescent," treating him as an adult when he is not really. They respond to this

with a feeling of being neglected and not being seen for what they are.

This is kind of a phenomenon particularly with those who go in the hospital, which is commonly done by the parents in the kid's early life. It then becomes a repetition on a social level of, you might say, a (250) pathological phenomenon which already caused harm in a family at an early childhood level and it's now institutionalizing him and society is going to do what the parents did and have something to do with the harm in the beginning.

Q. When you have recommended hospitalization of the juvenile, do you find that the juveniles are objecting?

A. Yes, they almost always object.

Q. How do you interpret that objection?

A. Well, this, I think, is such a common phenomenon that we see all the time, you would have to conduct your own little experiment to see how true it is and how stereotype it is.

You see the patient during admission and you see, perhaps as little as ten minutes later, him again when you are on the floor. It comes down to the interpretation of the meaning of behavior.

It is not so much what he says but what he means. And if I may backtrack a bit to what I said a moment ago, because he is in this state that he is dependent upon the parent and does not want to change that, adolescents do not communicate their feelings directly and verbally. So that when they are in pain and are having trouble, they express it by an action and very often it can be an anti-social action. They feel at this point (251) that their parents are scapegoating or rejection is an indication that the parents don't care, but they can't verbalize this because this

means an admission that they would like the parents to care, but the parents don't, and they cannot tolerate it. The way they express it is in behavior and this is what brings them into the hospital.

This is a way of relieving the feeling the parent does not care—by forcing the parent to do what is necessary for the adolescent's well-being.

In other words, for the parent to do for the adolescent what he can't do for himself, which is saying, "You have to go into a hospital because you are sick and you need help," and for the parent to do it over his objections and that is why I think he says no.

As I say, it is so common, we prepare the parents after we have done the evaluation and we say—they are terribly guilty. We say, "Are you so guilty about me that if I put the heat on you, you won't do what is in my best interest? Then that means you don't care about me."

So we prepare the parents after we have decided on hospitalization. The adolescent comes back and he will say things like, "I hate you. I'll never speak to you. Don't you realize what you are doing? These people are going to imprison me. I am going to be (252) tortured," and the parents say, "I'm sorry you feel this way, but it is in your best interest." It is a play or charade. This goes on in the office and when we take a kid down on the floor it disappears and you can see the relief on his face and then they start testing us and then they come and tell us what was going on and why they had to do what they did to get the help they needed.

This is why they say no and I think, by the way, that this is why it should be the parent who says, "You have to

go in the hospital," and not the Court. The parent is providing an emotional function vital to the adolescent at that time and I don't think the Court can ever be an effective substitute.

Q. Do you interpret this rejection as a plea for help?

A. The behavior—in other words, the anti-social behavior, we have characterized as a plea for help, as a way of describing why they are doing it, the fact they cannot communicate directly—so their plea for help is indirect. It is so common, that we advise adolescent psychiatrists for example, to not try to force the adolescent to admit how much he hurts and needs help at that time, because it will just drive him away, but to recognize that it is his very behavior which is the plea for help and accept it and start to work on that level.

I have one example that might illustrate (253) this. I saw a boy who is 16 and he was arrested for stealing at a prep school and brought down to my office for evaluation. He told me this story:

When he was 12 years of age, his mother and father were divorced and he went on to live with the mother. Three months before the Christmas vacation he came home to stay with his mother and he and his mother had a fight and his mother kicked him out and said he should go live with his father. He went to see his father and his father was living with his latest mistress in a hotel and had no room for him, and his father put him up in a hotel room and he spent the entire Christmas holiday reading a comic book and watching television and he went back to school and wrote a theme which he was going to do. Then he started stealing articles from homes and he walked by a policeman and started stealing and was apprehended.

The parents were called and he took all of them to his dormitory and his footlocker, where he had carefully wrapped and stored everything, and this is how he got help.

Q. How do you feel about providing a hearing for an adolescent when the parent agrees with the recommendation of the psychiatrist to hospitalize their child?

A. To repeat what I said before, I am against it, (254) is as if their rights are not being respected, for us to act and to demand and require of them all kinds of conscious, verbal things that they cannot do and are not interested in, and it is a kind of vacillation in carrying out the effective role of the parent in dealing with the problem.

He's already made his statement in his behavior; why does he have to go into Court and go through the whole thing again?

Q. How would an unstable set of parents be operating in the best interests of their children?

A. Well, I think every parent of every patient we see can be called unstable, so that it is a more complicated phenomenon. They are all unstable in some ways.

Now, it depends to a great extent on the way in which their instability affects their role as a parent. There are some people who can, for example, be very effective at their work, but when they come home, they're hell with their children. There are others who after the kids go to bed at seven or eight o'clock at night, they are alcoholic all night; for the rest of the day they manage to perform a parental function.

It's a more complicated problem as to whether they are unstable or not. There are several things about this.

Even parents who are quite disturbed are generally (255) not disturbed all the time and even though a child may play, let's say, a pathological role in their life, for the most part, there is always a part where he does not.

It is over and above the fact that they do have problems. They also want to be a good parent; not just because they have this function now to perform, like to be a good lawyer or good doctor, but it seems to me there is something in the human personality because I hear this theme repeated over and over again. Once you have grown up yourself and once you become an adult, and have a child, one of the key motivating forces is you do not want to repeat the traumas on your child that you received yourself while you were growing up, no matter how large or small, so this also motivates them.

Q. Doctor, do you believe there should be different admission procedures for adults than for juveniles?

A. Yes.

Q. Why?

A. It seems to me I have said it already.

For the same reasons. I think they are different and I think we should recognize this difference and it should be reflected in the law just as it is reflected in psychiatry. For example, we now instead of having the adolescents with the adults in the hospital, we have them in their own unit because this reflects their emotional (256) needs.

Q. Doctor, in Pennsylvania, we provide a hearing for a juvenile age 13 to 18 if he objects at, or subsequent to, admission.

Do you feel that hearing is harmful at that time?

A. I think it can be harmful. It's not necessarily harmful. I think it's a different cup of tea than having a hearing before he gets into the hospital, because those

dynamic and emotional functions that I have mentioned have already been performed. The patient has made his statement in his behavior and the parents have responded and that framework has now been set up for treatment and for, you know, dealing with the problem. Once he gets into the hospital and then he wants out or he wants a hearing, the parents are more or less out of it.

So I think it is a different cup of tea. I think—I have often seen it be harmful where they are allowed out of the hospital and don't belong out of the hospital.

MR. ROTH: Your Honors, I have no further questions.

Cross-Examination

BY MR. FERLEGER:

Q. Dr. Masterson, the hospital or clinic that you have been discussing that you work at is the Payne-Whitney Psychiatric Clinic of the New York Hospital?

A. Yes.

Q. That institution, that Payne-Whitney Clinic, accepts adults as well as children?

A. Yes.

Q. And, the total population, adults plus children, is just over a hundred; is that right?

A. Yes.

Q. And, the total number of high school aged kids is about eleven; is that right?

A. It averages about that. Sometimes more.

Q. Do you have children there, younger than high school age right now?

A. No.

Q. Do you accept children younger?

A. No.

Q. And, the cost per day is about $180.00 per day; is that right?

A. Yes.

Q. It's more than the Institute here in Pennsylvania; isn't it?

A. What is that?

Q. The Institute—

A. I know. What is the cost?

(258) Q. $120.00.

JUDGE BRODERICK: That was the charge, not the cost.

MR. FERLEGER: Yes.

Q. How many psychiatrists are on your staff that are mainly concerned with the eleven or so juveniles that you have?

A. Well, we have a rather—maybe a unique arrangement. We have all the residents in training in their second year musing through the program, so that we have at any one time, we will have—if we have eleven patients, we will probably have eleven second year residents.

We will have two third year residents who we call the chief residents, who are administrators of the program and over and above them we have like five graduate psychiatrists who are supervisors.

Q. Did I understand you to say you have eleven patients, eleven psychiatrists who are residents, plus more than five supervisors and administrators?

A. That's right.

Q. Is there any institution that you know of with a greater doctor-patient ratio?

A. No.

Q. Doctor, you heard me earlier ask Dr. Miller—

A. Let me, if I may, briefly elaborate—

(259) Q. Can you wait to elaborate—

JUDGE GIBBONS: If it relates to the previous answer, elaborate now.

A. There is a reason. We have a one-to-one—because of what we are teaching, we are trying to teach intensive psychotherapy which requires intensive contact over a long period of time so they only get one patient, you see, and if they were getting lots of patients, if they had a lot of patients, the ratio would be quite different.

Q. Most state facilities do not involve the teaching of psychotherapy on that long a basis; is that right?

A. That's correct.

Q. Doctor, in the introduction to the book you edited, Teaching and Learning Adolescent Psychiatry, that I mentioned earlier, you note with apparent approval and your words are, and if you'd like to see the book, I have it here for you.

A. Yes, I'd love to. It's been a long time.

Q. To refresh your recollection (indicating), your words are, "In Georgia, the governor has just signed to law a provision that teenagers may get psychotherapy without the permission of their parents."

Do you approve of such a law?

A. I don't know if I approve of it in that form. I do think that they should be able to apply for help without (260) permission of their parents.

Q. Now, Doctor—

MR. ROTH: Excuse me, had you finished with your answer?

THE WITNESS: No.

A. Then, I think what should happen is that at the appropriate moment—in other words, the psychiatrist should be able to see them without having parental permission first. At the appropriate moment in the evaluation the parents should be brought in and hopefully there would be a consensus among them as to the need for treatment.

Q. If there's a disagreement?

A. I would be in favor of a hearing.

Q. If the child felt that the child needed help and the parents said no.

A. And the psychiatrist thought the child needed help a hearing would be in order.

Q. Even though that hearing might conflict within the parents duties and role as a parent?

A. Yes. May I give you the reason because it sounds like a contradition. It isn't.

I think in medicine in general, there is a conservative principle of treatment and that is that you don't do any more than you have to do—you don't take any more risks or take on any more possibilities (261) of danger that you have to take in order to deal with the problem at hand. I don't think the family unit should be disturbed for the reasons I mentioned. However, under certain circumstances which go beyond that, in other words, there will be greater harm in not doing this than in doing it, I think it should be done. That is one of the examinations.

Q. It is true in many cases of children who have emotional problems as one described in your book, Borderline Syndrome. In those cases the parents are not good observers of the child's symptoms; is that true?

A. Yes.

Q. In fact the parents may have been unconsciously provoking the behavior of the child.

A. Yes.

Q. This would apply to the anti-social or acting-out behavior we have talked about?

A. It could, yes.

Q. Now, Doctor, there will also be many cases where the child may be driven to such behavior by the conflicts at home, isn't that right?

A. That also can happen.

Q. Now, there is a phenomenon, Doctor, in psychotherapy which I am certainly not an expert on, called "counter transference," where psychiatrists have difficulty dealing (262) with the conflicts aroused in themselves by their parents' needs and desires.

Isn't it true, Doctor, that in this situation the psychiatrist may become unable to recognize or to explore the patient's conflict in some situations?

A. This is a possibility, sure.

Q. In those situations, the psychiatrist's difficulties in perceiving what is going on can block therapy and result in an improper evaluation; isn't that so?

A. That's true. I'd like to add to that.

It seems to me here, you are not talking so much about psychiatrists, but you are talking about human nature and I think that phenomenon you have described can occur anywhere.

Q. I agree.

A. And—all right.

Q. Doctor, in situations where, for example, you have a schizophrenic evaluation of a child, you have found in your research, haven't you, that usually at least one of the parents has a pathological attitude toward the child; isn't that right?

A. That's right.

Q. And, that very often, the children are resentful and hostile towards parents, so there is a conflict?

A. That's right.

(263) Q. And usually, there is a rather overt conflict between the parents and the child; is that right?

A. That's right.

Q. Doctor, New York law, as you may be aware, allows for the commitment of anyone, adults as well as children, for that commitment to occur on a certificate signed by two doctors; is that the law in New York?

A. Yes.

Q. Do you believe that sort of admission procedure is a proper one?

A. Am I in favor of that for adults, for adolescents or for everybody?

Q. Right.

A. As I understand it, you are able to have them committed on two physicians' certificates for up to ten days when they must have a court hearing.

Q. Are you certain of that?

A. I am pretty sure of it. I am not certain of it.

Q. Well—

A. Yes, I am in favor of it.

Q. You are in favor of it for ten days or you would be in favor of it if it's indefinite?

A. No, not if it's indefinite.

Q. You would not be in favor of two doctors' certificates for indefinite periods?

(264) A. No.

Q. How about for children?

A. The parents should have to perform this function, and if the parents do not, the Courts should.

Q. Having two doctors' certifications for an indefinite commitment of a person under 18; are you in favor of that?

MR. ROTH: Objection, your Honor. I believe he has answered that question.

JUDGE GIBBONS: No, I don't think he did with respect to the people under 18.

MR. ROTH: I think he addressed himself to juveniles under the distinction.

JUDGE GIBBONS: It certainly isn't clear to me.

Another thing that isn't clear is, you have shifted ground from what the Doctor perceives to be the New York statute which has a ten-day limitation and an indefinite stay.

MR. ROTH: We can refer later to what the New York statute says. I am asking the Doctor whether he wouldn't agree—

JUDGE GIBBONS: I want to be sure that the record is clear in each answer.

Q. Let me repeat the question, Doctor, and make it very clear.

(265) Without reference to the particular provision under New York law, would you favor two doctors' medical certifications for commitment of persons 18 or under for an indefinite period?

A. No.

Q. Would you favor commitment of juveniles with two doctors' certifications with the parents' application for an indefinite period?

A. You are assuming here, that the adolescent objects?

Q. That's correct.

A. No, I think he should be put in the hospital and then I think he should have a hearing.

Q. So, you do not feel then, that just because the parents and the doctors want the child in the hospital, that should be enough reason to keep the child in without a hearing? You do feel a hearing should be provided if the adolescent objects?

A. That right.

Q. Even if that objection comes from this adolescent confusion and turmoil?

A. I think, and it has been my experience, and we have had it in our unit, that since it is an integral part of what is wrong with him, this law has given a weapon to this type of thing where he will sign out—

Q. What do you mean?

(266) A. In New York State we have a law that after they are admitted, if they want to leave, they sign a letter and within 24 hours they must be given the services of a lawyer from the mental health commission and either, in three days, we either have to commit them on the two physicians' certificates or we have to let them go.

Q. Do you feel it's destructive?

A. To them, yes.

It's not until they get through the testing phase of their treatment and get into the relationship and start to work on their problems that they realize the function of what they are doing.

Q. How long does the testing phase take?

A. Three months to six months.

Q. You would be in favor of them not getting the hearing until three months or six months later?

A. Yes. You take this rebellious and negativistic testing teenager who is in the first phase of treatment, all you are talking about is why did he did this and that, and once that happens, you get control of the behavior and once he feels he can trust you and he thinks you know what you are doing and he has not met many adults whom he's had the right to feel that way about them, the whole picture changes and he goes back and reviews everything that has happened and I think I have documented that in this book, (267) and he tells you exactly what he was feeling, which he was unable to say before, and he describes these and at this stage in the treatment if he went before a Court I think he knows and is able to act in his best interest.

Q. So, you would feel that Pennsylvania regulations which allow hearings to be requested within a couple of days, that those would also be destructive?

A. I think they could be very destructive.

Q. Doctor, one further question; it is more a request for an explanation.

You stated in your article in the American Journal of Psychiatry in 1967, "Symptomatic Adolescent Five

Years Later," you said, "I consider, unless I can prove otherwise that my patient has a psychiatric illness."

Now, do you feel that other psychiatrists also share that basic presumption of a psychiatric illness unless it is proven otherwise?

A. I think you have to understand that comment in the context with which it was made, and at the time in which it was made. When I first started in adolescent psychiatry, the dominant theme in the field and that's how this paper is an outgrowth of like ten years of research on this question, the dominant theme in the field was when you see an adolescent, most likely, what is wrong with him has to do with the fact, you know, that he is (268) in this growth stage and it is probably due to that and when he gets over that, it will disappear. And, this attitude on the part of adults towards adolescents goes all the way back to Socrates. However, it was in the literature and it was probably by far the most dominant theme. The result being when adolescents came for evaluation, first of all they were difficult to evaluate and also at that time, we didn't know anywhere near what we know now, there's been such a knowledge explosion in adolescent psychiatry in the years I have been in it, so the psychiatrist was feeling insecure.

So what did he say? "Don't worry about Johnny, he is an adolescent, and when he gets over this he will be better," and every year Johnny's pathology is getting worse and worse and at age 22, after five years and he is out of his adolescence, he is now in a state hospital with a very long term.

All right, this was the context and I did the study and found out it was never growth, it was always psychiatric illness. The psychiatrist should not be thinking about growth but he should be thinking about illness, and the burden of proof should be on him to show the guy is not ill.

Q. The burden of proof on the psychiatrist or patient?

A. The psychiatrist.

(269) Q. The psychiatrists should first assume the person is ill and then try to prove otherwise?

A. I think he should—if we are talking about an adolescent, I think he should assume for the purpose of his own intellectual processes that this phenomenon is more likely illness than growth and then rule out illness and then come to the conclusion of growth rather than the other way around.

Q. Just one final question.

The testing phase you described, this process where at first people say, "I don't want to be in the hospital. I didn't act crazy."—do these things— and then after a while they begin to gain what doctors often call "insight" into their behavior; that happens with adults, too, does it not?

A. Sure.

Q. So, you may have for example, and if this is correct, I have had clients that have been involuntarily put into mental hospitals and after a few months of protesting and not getting out, they suddenly say, "Yes, I really am sick;" isn't that right?

A. Yes, certainly.

Q. So, would you feel then, that the law should also, as is said for juveniles, that adults should not be able to request an automatic hearing until after the testing (270) phase for adults is concluded?

A. I would feel what you have there is an adolescent adult and I would hope this is an exception.

This phenomenon is common; it is part of adolescence. It is not the part of the adulthood.

MR. FERLEGER: No further questions.

MR. ROTH: Just one question.

Redirect Examination

BY MR. ROTH:

Q. In the event a parent brings his or her child to you and you recommend hospitalization and the parent objects to it and the child is indifferent towards it, but is definitely in need of care, what can you do to make sure the child receives care?

A. This will depend upon the degree of need on the part of the child.

Q. Let us assume the degree of need is great, where you would feel professionally badly if that child did not receive hospitalization promptly.

A. The first thing I would try to do is work more with the parents so to see if I can get them to accept it.

If I could not get them to accept it, depending on how bad it is, there's a—I can't remember the name. There's an agency you can call and they will send a social worker in to investigate the family and to (271) take a role in this determination.

MR. ROTH: I have no further questions, your Honors.

JUDGE GIBBONS: Thank you, Doctor.

JUDGE BRODERICK: Good to see you.

THE WITNESS: Nice to see you.

(Whereupon, the witness left the stand.)

MR. ROTH: We did not bring the third witness with us today. We anticipated calling him the first thing on October 7th.

JUDGE GIBBONS: You will get one additional witness.

MR. ROTH: We will have an expert and one witness testifying as to the introduction of the effectiveness of the regulations since they have been published in September of 1973.

MR. FERLEGER: I understand that Mr. Roth is referring to the Exhibit that we discussed on Monday, which lists institutions around the state and I cannot see how one witness can be competent to testify to anything except that he made some phone calls.

JUDGE GIBBONS: I notice that you may have an evidence problem. Will you have any reputable testimony?

MR. FERLEGER: No, your Honor. We have (272) given the Court our Exhibits which are already numbered seven—Dr. Armstrong's deposition —and as soon as we get it signed, we will be submitting Dr. Finer's deposition, which the Court has already ruled can be admitted as a trial deposition.

That will be all the evidence from the plaintiffs.

JUDGE GIBBONS: And both sides will be prepared to p:esent concluding arguments on the 7th, and we will finish the case that day?

MR. FERLEGER: Yes, your Honor.

MR. ROTH: Your Honor, if I may, with regard to Dr. Tashjian's Curriculum Vitae, I would like to have that marked as defendants' Exhibit 10, and on October 7th I will be prepared to introduce additional Exhibits for your ruling.

JUDGE GIBBONS: All right.

(Whereupon, the Curriculum Vitae of Dr. Tashjian was marked defendants' Exhibit 10 in evidence as of this date.)

JUDGE GIBBONS: We will recess then, until the 7th.

MR. FERLEGER: Thank you, your Honor.

MR. ROTH: Thank you, your Honor.

(Whereupon, at 12:17 p.m., Court was adjourned.)

EVIDENTIARY HEARING

Before: Hon. Daniel H. Huyett, 3rd, J.

Third Day

Philadelphia, Pa., October 7, 1974

(10:00 A.M.)

Present:

David Ferleger, Esq., Attorney for Plaintiffs, Mental Patient Civil Liberties Project, Philadelphia, Pa. 19107.

Barry Roth, Esq., Assistant Attorney General, Attorney for Defendants, Office of Legal Counsel, Department of Public Welfare, Harrisburg, Pa. 17120.

(275) (All Counsel being present, the following transpired in open court:)

THE COURT: Good morning, gentlemen.

MR. FERLEGER: Good morning, your Honor.

MR. ROTH: Good morning, your Honor.

THE COURT: It is my understanding from information given to my office last week, that the defendants have no further testimony and if that is the situation, then, we are concerned with closing the record today and determining the admissibility of exhibits, setting a briefing

schedule after the notes of testimony have been transcribed.

Is there any comment from Counsel?

MR. FERLEGER: That is my understanding, your Honor.

MR. ROTH: That is correct, your Honor.

THE COURT: All right, very well.

Perhaps we could determine what exhibits have been admitted and we can start from there. According to my notes, Exhibit P-1 has been admitted; P-4 has been admitted; P-5 has been admitted and P-6 has been admitted.

Also P-8 has been admitted, and on the defendants' side, my notes indicate we have admitted D-10, D-11, and D-12.

Would Counsel agree with me on that?

(276) Are there any others that have been admitted other than those that I have mentioned?

MR. FERLEGER: I don't believe so, your Honor.

MR. ROTH: No, your Honor.

THE COURT: What other exhibits are we concerned with today, gentlemen?

MR. FERLEGER: For the plaintiffs, Exhibits 2 and 3 were presented to the three-Judge Court at our last hearing and I believe Judge Gibbons commented the Court would reserve ruling on plaintiffs' Exhibits 2 and 3.

THE COURT: What are 2 and 3?

MR. FERLEGER: Number 2 I don't see any problem with, because it is part of the final order, stipulated

facts, the Governor's task force on mental health of children and youth. It is their report on the issues in this case and most of that report is already in the record in the final order.

THE COURT: Is there any objection, Mr. Roth, to the Exhibit P-2?

MR. ROTH: Your Honor, we had objected to the admission of that as being irrelevant.

THE COURT: Is that the only reason for not admitting it?

(277) MR. ROTH: Yes, your Honor.

THE COURT: How is this relevant, Mr. Ferleger?

MR. FERLEGER: Your Honor, it is relevant in two senses: One, because it is the report of an official task force of the Pennsylvania government which made a recommendation to the Department of Welfare, contrary to the regulations they adopted.

It is relevant, also, because just on its face, the arguments and the reasons it gives on behalf of its conclusions, it seems to me, may be permissive to the Court.

It is at paragraph 33 of the final order; most of the report is reprinted at that paragraph.

There is no objection by opposing Counsel to doing that.

THE COURT: Is this a matter that the three Judges specifically took up?

MR. FERLEGER: No.

MR. ROTH: No.

THE COURT: Counsel, a moment ago, stated that we would reserve our rulings on P-2 and P-3. Where did you get that from?

MR. FERLEGER: That is my recollection of the last hearing. I believe Judge Gibbons said to me, (278) "Is there any need to rule on P-2 and 3 at this time?" I answered that there wasn't and I believe that he said that the Court would wait.

THE COURT: Your only objection, Mr. Roth, is relevancy?

MR. ROTH: Yes, and if I may, there has been a mistake in that this is not the Governor's task force. It is the task force on mental health in children and youth. It was not directed by the Governor's office. We have numerous task forces within the Department of Public Welfare which are convened to make recommendations to other councils in the department.

Their recommendations are not binding. It is merely advisory and we feel this report is irrelevant.

THE COURT: Is this the report of a private organization?

MR. ROTH: This is the report of a task force that was convened by the Secretary of Public Welfare of the Department of Public Welfare on children and youth. And they report directly to the Secretary of Public Welfare.

MR. FERLEGER: The defendants' second set of interrogatory replies responded that was an accurate copy of the task force report and gave information as to who the members of the task force were and how it was (279) appointed and to whom it made recommendations.

It seems to me an official government report on the propriety of the recommendations as to what are partly in dispute are extremely relevant to this case.

THE COURT: Any further comment from Counsel on P-2?

MR. FERLEGER: No, your Honor.

MR. ROTH: May I, your Honor?

THE COURT: Yes.

MR. ROTH: Thank you.

With regard to the substance of the report, I merely make one observation and that is that the plaintiffs in this lawsuit seek a judicial hearing for every juvenile whether they object or not and in that particular report, it addresses itself to whether or not a juvenile objects. So it is more restrictive than what plaintiffs seek.

I register an objection again, on the basis of the relevancy. Otherwise, we could provide numerous reports of every task force convened and I think it would not do this Court justice in that respect.

THE COURT: Gentlemen, I will take under advisement the admissibility of P-2.

What about P-3; is that the same thing?

MR. FERLEGER: With regard to P-3, there (280) is more of a problem. This is an affidavit which was filed with the Court some time ago, more than a year ago, I believe, when we mentioned it in our proposed final order and Mr. Roth stated he did not know it was in the record.

Dr. Ginsburg, as I told your Honor at our conference in chambers on the final hearing order, is in South America.

He left, I think, the beginning of August and was unable to be here to testify. The content of his affidavit in a way is a statement of his feelings as an expert on the various matters involved in the commitment of children.

We think that this may be of assistance to the Court.

THE COURT: Mr. Roth?

MR. ROTH: Thank you, your Honor.

Again, we objected to this, and first, may I state for your Honor that we had not received a copy of this when it was allegedly sent a year ago and we had brought this to Mr. Ferleger's and the Court's attention when the pre-hearing order had been drafted.

Upon reading that, we would have continued to object had we noted it a year ago. We found it was irrelevant; that the document, itself, could not be cross-examined; and as your Honor well knows, there (281) have been several experts who have testified and we feel their testimony would be the best evidence, since both parties have had a chance to directly and cross-examine those witnesses.

THE COURT: Anything else on P-3?

MR. FERLEGER: I hope Mr. Roth applies the same reasoning to his affidavits.

Nothing more on P-3.

THE COURT: We can't have this admitted by stipulation, in other words?

MR. ROTH: I would not be willing to, your Honor.

THE COURT: I will take the admissibility of P-3 also under advisement.

What else do we have, gentlemen?

MR. FERLEGER: Your Honor, the plaintiffs have two depositions, which by the pretrial order, I believe were ordered to be admitted.

One is the deposition of Dr. Barbara Armstrong, and I guess we should take that up first.

Mr. Roth sent me, and I just received today, a letter objecting to the underlining on about five or six of the pages. I think we can either resolve which lines are to be underlined or I am willing to omit those entire pages so we don't have to waste time.

(282) THE COURT: What is the purpose of the underlining?

MR. FERLEGER: To eliminate colloquy and other irrelevant matters from the deposition.

THE COURT: There is no question on the admissibility of the deposition? Counsel attempted to purge portions which were not of material importance and which we were not concerned with and this is the hang-up; is that correct?

MR. FERLEGER: Yes, there is only seven pages which there is disagreement on, and I am willing to omit those pages, if Mr. Roth is, because there is no necessity to worry about one or two lines.

THE COURT: What are you agreeing to?

MR. ROTH: Your Honor, it is my understanding, according to your order of August 21st, that we would underscore the portions agreed upon—

THE COURT: The underscored portions should be purged and not considered?

MR. FERLEGER: The underscored portions should be considered and those parts disagreed upon we subsequently resolved that by underscoring those parts in accordance with your order.

THE COURT: If you can't agree, it is admitted.

(283) MR. ROTH: Yes.

THE COURT: Can Counsel work this out and file something?

MR. ROTH: I can agree with Mr. Ferleger on admitting those parts that he has just addressed himself to.

MR. FERLEGER: Can we agree to admit the entire pages?

MR. ROTH: That would be fine.

THE COURT: For the record, what is the number of this deposition?

MR. FERLEGER: My copy—I don't have a number on this. Since it has not been admitted, your Honor, perhaps I should give it a number.

THE COURT: Is this a plaintiffs' exhibit?

MR. FERLEGER: Yes. The last one we have is number 6 and number 8 was a brochure from the Institute of Pennsylvania Hospital. So, I believe this may be number 7.

THE COURT: Number 7 is the accreditation manual for psychiatric facilities and number 8 would be the brochure from the Pennsylvania Hospital which was admitted. Would this be P-9?

MR. FERLEGER: Yes.

THE COURT: All right, the Armstrong (284) deposition will be P-9.

MR. FERLEGER: For the record, plaintiffs move the admission of P-9 with the parts that are underlined in the Court's copies to be admitted with the exception of the following pages, all of which are to be admitted: All of pages 11, 28, 30—

THE COURT: Just a moment. 11?

MR. FERLEGER: 11, 28, 30, 55, 64, 67, 68, and page 123. For those pages, the parties agree that the entire pages are to be admitted.

THE COURT: Do you have any comment on that, Mr. Roth?

MR. ROTH: No, you Honor. That is fine with us.

THE COURT: In other words, the entire deposition would be admitted—let me start over again.

The Armstrong deposition is Exhibit P-9 and those parts of that deposition which are underlined are to be admitted and in addition, pages 11, 28, 30, 55, 64, 67, 68, and 123?

MR. FERLEGER: That's correct.

THE COURT: All of that will be admitted in evidence?

MR. FERLEGER: That's correct.

THE COURT: Fine.

(285) (Whereupon, the deposition of Dr. Barbara Armstrong as outlined above, was received in evidence and marked as plaintiffs' Exhibit 9 as of this date.)

THE COURT: What else?

MR. FERLEGER: Plaintiffs have one further exhibit which has been docketed and copies have been sent to the members of the Court. I was told before you came in that the originals are probably in your chambers.

It is the deposition of Dr. Joel Finer, which by the pretrial order was ordered to be admitted. It has been signed and sent to the court reporter for certification and filing and that deposition, which I believe your law clerk has, I move to have admitted.

THE COURT: This is document 80 in the file of the clerk?

MR. FERLEGER: Yes, I believe so.

THE COURT: Deposition of Dr. Joel S. Finer, M.D., taken August 21, 1974.

Any comment, Mr. Roth?

MR. ROTH: No.

THE COURT: Shall we mark this P-10?

(Whereupon, the deposition of Dr. Joel S. Finer, M.D., was received and marked in evidence as plaintiffs' Exhibit 10.)

(286) MR. FERLEGER: Plaintiffs have no further exhibits or testimony in this matter.

THE COURT: All right, thank you.

MR. ROTH: Your Honor, I have one question, if I may, regarding plaintiffs' exhibits.

I am not certain which plaintiffs' Exhibit 7 was.

THE COURT: According to my notes, it is a manual of accreditation for psychiatric facilities.

MR. FERLEGER: That's correct, your Honor. The record will indicate that it is the Joint Commission on Accreditation of Hospitals' new manual on psychiatric facilities for children and adolescents.

Dr. Kandler, I believe, in his testimony referred to it and it was marked for identification only and was not admitted as an exhibit.

THE COURT: In other words, P-7 was not admitted?

MR. FERLEGER: That's correct, your Honor.

THE COURT: All right.

MR. ROTH: Your Honor, we would object to that—

THE COURT: It is not admitted. It is just simply marked. It is not part of the record.

(287) MR. ROTH: Fine.

THE COURT: Plaintiff has nothing further to offer by way of exhibits?

MR. FERLEGER: That's correct, your Honor.

THE COURT: Mr. Roth?

MR. ROTH: Thank you, your Honor.

We have prepared a list of our exhibits which we sent your Honors and Mr. Ferleger and it is my understanding that there is no disagreement and the following can be introduced into evidence:

Defendants' Exhibit 1—

THE COURT: Will you describe briefly each one?

MR. ROTH: Fine.

THE COURT: And at the end of each exhibit, we will consider the admissibility of each exhibit.

MR. ROTH: Thank you, your Honor.

Exhibit 1, your Honor, is the May 31, 1973 questionnare submitted to all mental hospitals, state schools and hospitals regarding impatient psychiatric care. There were numerous questions on that particular questionnaire which were responded to.

THE COURT: Any objection to D-1?

MR. FERLEGER: D-1 is the questionnaire (288) that was sent out in response to the Court's order that plaintiffs' interrogatories be answered and we have no objection to their questionnaire being admitted.

THE COURT: D-1 is admitted.

(Whereupon, D-1, previously marked for identification was now received in evidence.)

MR. ROTH: D-2, your Honor, are the additional procedural safeguards for juveniles admitted to institutions and so labeled and found in the Pennsylvania Law Bulletin, Volume 3, Number 37, adopted September 1, 1973.

There is a mistake on the cover sheet of the defendants' exhibits which I prepared which says September 1, 1974. It should read, "September 1, 1973."

MR. FERLEGER: No objection, your Honor.

THE COURT: D-2 is admitted.

(Whereupon, the so-marked D-2 is received in evidence.)

MR. ROTH: These exhibits were agreed to in the prehearing order. Defendants' Exhibit 3 are the answers to the questionnaire of May 31, which also was agreed to in the prehearing order.

THE COURT: Any objection to D-3?

MR. FERLEGER: No, your Honor. I understand D-3 is the very large volume of responses by each (289) institution about children in mental hospitals and we have no objection.

THE COURT: D-3 will be admitted.

(Whereupon, the so-marked D-3 is received in evidence.)

THE COURT: May I comment that Counsel should meet with my law clerk to make sure we have all the exhibits and they are all properly labeled, since this is getting to be a rather thick record; that we have all that we should have. I would appreciate that very much.

Would you continue, Mr. Roth?

MR. ROTH: Yes, your Honor.

Exhibit 4 is the admission note of Donn Dickel, which I understand there is no objection to.

MR. FERLEGER: There is no objection to Exhibit 4, your Honor.

THE COURT: D-4 is admitted.

(Whereupon, the so-marked D-4 is received in evidence as of this date.)

MR. ROTH: Defendant 5 is the admission note of Alan Moss which I understand there is no objection to.

MR. FERLEGER: No objection.

THE COURT: D-5 is admitted.

(290) (Whereupon, the so-marked D-5 is received in evidence.)

MR. ROTH: With regard to Defendants' Exhibit 6 and 7, which we had alerted your Court to a few weeks ago, we wish to withdraw those exhibits.

THE COURT: Very well.

MR. FERLEGER: Which exhibits?

MR. ROTH: Dr. Kratsa's affidavit of Alan Moss and Dr. Gus Kratsa's affidavit of Don Dickel.

Exhibit 6 would now become patients profiles which were agreed upon in the prehearing order and we have received no objections to that.

MR. FERLEGER: There is no objection, your Honor.

THE COURT: The new D-6 is admitted.

(Whereupon, the so-marked D-6 is received in evidence.)

MR. ROTH: Defendant Exhibit 7 would be the pretrial deposition of Dr. Max Sugar.

MR. FERLEGER: No objection to Dr. Sugar's deposition.

THE COURT: D-7 is admitted.

(Whereupon, the so-marked D-7 is received in evidence.)

MR. ROTH: Your Honor, if I may state (291) for a moment here, with regard to the Curriculum Vitae of the three expert witnesses, as is recalled, we admitted them as Defendants' Exhibits 10, 11, and 12.

However, our numbering is now going to be augmented, since we have withdrawn Exhibits 6 and 7.

Shall we renumber those exhibits?

THE COURT: No, they can remain 10, 11, and 12. It might be confusing to renumber them.

MR. ROTH: Your Honor, shall I reflect what those exhibits were, 10, 11, and 12, if there is any problem?

THE COURT: You might for the record.

MR. ROTH: Thank you, your Honor.

For the record, Exhibit 10 is the Curriculum Vitae of Dr. Levon Tashjian. Exhibit 11 is the Curriculum Vitae of Dr. Derek Miller, and Exhibit 12 is the Curriculum Vitae of Dr. James Masterson.

Your Honor, Defendants' Exhibit 13 is ten other states' admission policy regarding juveniles. In particular, they are the laws of ten other states which we would respectfully request that this Court take judicial notice thereof.

THE COURT: Any objection?

MR. FERLEGER: I don't object to the Court taking judicial notice of any state statutes.

(292) I do object to Mr. Roth selecting which statutes are selected. I don't believe this is a proper evidentiary exhibit, because it does not tend to prove any fact in this case.

THE COURT: D-13 is a compilation of other state statutes. D-13 will be admitted and if you wish to argue any other statutes, Mr. Ferleger, you may do so.

(Whereupon, the so-marked D-13 is received in evidence.)

MR. ROTH: Defendant Exhibit 14 is labeled "Pennsylvania Laws Affording Adults' Rights While Not Visiting Similar Rights Upon Juveniles."

Again, we would request that this Honorable Court take judicial notice of those laws.

MR. FERLEGER: Your Honor, again, I am not sure of the accuracy of the compilation. It is a selection from Pennsylvania Statutes that the defendants have made. I don't know if they are accurate. I don't know if there are other laws which also involve juveniles that have not been included and I think the Court can take its own judicial notice of whatever laws in Pennsylvania exists.

THE COURT: Mr. Roth?

MR. ROTH: Your Honor, Mr. Ferleger has (293) been apprised of this summary as early as March, I believe it was, of 1973, when I attached a copy of these laws to my motion to my memorandum of law and we merely updated them.

The compilation has been prepared with our office and the Attorney General's office. Certainly, if there are other laws we have left out, we would be more than happy to have these admitted, also.

MR. FERLEGER: Let me just note that the exhibit itself is labeled with the labeling consistent with what Mr. Roth has labeled it.

Exhibit 14 is labeled, "New Laws Lowering Age Limit From 21 to 18 Years." So these are not laws not giving juveniles rights. These are new laws passed by the legislature all in 1972, involving lowering of age limits from 21 to 18. That takes us even further afield from this case.

There are laws about engineers having charge of steam boilers and insurance agents and assessment of taxes; laws involving second class cities and incorporated towns. These are those new laws that the legislature passed involving age limits and lowering of age limits. I don't see what this has to do with this case.

THE COURT: Mr. Roth, you are representing (294) D-14 as accurate and correct and you believe relevant?

MR. ROTH: Yes, your Honor. We feel that these laws reflect when one is 18 years of age or older, what he or she may or may not be able to do in accordance with the laws of Pennsylvania, while not visiting similar rights upon those younger than 18, which we feel is a very significant point in this lawsuit.

THE COURT: Well, to resolve the matter, gentlemen, and consistent with my ruling on D-13, I will admit D-14.

If any part of D-14 is not accurate or correct, I assume plaintiff will point that out in plaintiff's brief.

MR. FERLEGER: Thank you, your Honor.

MR. ROTH: Thank you.

(Whereupon, D-14 is marked in evidence.)

MR. ROTH: With regard to Exhibit D-15, your Honor, this is reflected as to how the September, 1973,

regulations are working as of April 2, 1974. At this time, I would like to introduce in accordance with this exhibit an affidavit prepared by Mr. Ralph Phelleps and Mr. Richard Barbush.

If I may explain the purpose of this first—

THE COURT: Yes. Then you may respond, (295) Mr. Ferleger.

MR. ROTH: Thank you, your Honor.

Your Honor, in September, 1973, we published regulations which basically permit juveniles a hearing, age 13 to 18, if they object at or subsequent to admission. Prior to an April 16, 1974 hearing, I had requested the Office of Mental Health to ascertain how these regulations were working. At that time, Mr. Ralph Phelleps, who was in charge of the collection of this particular datum, proceeded to collect the same. He outlines exactly what his procedure is in outlining that data.

He worked jointly with a person from the Office of Mental Retardation. The reason I bring these affidavits and not the people themselves is because I think the people themselves would merely testify as to the procedure utilized.

In other words, Mr. Phelleps, as is indicated, prepared with Mr. Barbush, as is indicated, the questionnaire letter to be sent. That letter was sent to the regional Deputy Secretaries to the attention of the Regional Commissioners. And they in turn notified the superintendent and administrators of the state institutions and subsequently the superintendents of the institutions and administrators delegate a staff member (296) to collect that data. After the data is obtained at the state or private institutions, it

is provided to the appropriate retardation and mental health commissioner who in turn forwards it to Mr. Phelleps' and Mr. Barbush's office, and this will show also the letter drafted by these two gentlemen which was sent out over the signature of Mr. Gregory L. Coleman, the Deputy Secretary and we submit this is an ordinary business practice in Pennsylvania to disseminate or obtain information from our facilities.

We realize the best way to present this would be to bring the person who collected the data from each institution. As I may recall the Court's attention, there are 20 state schools and hospitals and 10 state mental hospitals and 164 private licensed facilities. We would respectfully request that this exhibit be introduced.

THE COURT: Along with the affidavits?

MR. ROTH: Yes, your Honor.

THE COURT: And this is D-15?

MR. ROTH: Yes, your Honor.

THE COURT: If I were to rule against you, how would you then have to get this evidence in the record?

MR. ROTH: I think the only other way (297) to present this evidence would be to bring in the person from the various institutions and I am somewhat dismayed to have to say that.

I did indicate to your Court we would not bring in any other witnesses. We feel this may be an exception to the hearsay rule, if you will, based on the customary practice.

THE COURT: Mr. Ferleger, what comment do you have?

MR. FERLEGER: I have a number of comments, sir.

First, the hearing originally scheduled for this morning before the three Judges was to include testimony by the affiant here, Mr. Ralph Phelleps. I understood Mr. Ross was foregoing his testimony and it was implied to me, at least, there would not be any necessity for that exhibit to be introduced.

Mr. Roth was on notice, of course, because at the last hearing we had with regard to this hearing, Judge Gibbons stated at page 7, on the sixth line or so:

"I think he would be entitled to cross-examine. The summary could go in if you had a witness here that he could cross-examine. I don't think it could otherwise."

(298) THE COURT: This is specifically on this exhibit?

MR. FERLEGER: That's correct.

Further down, Judge Gibbons stated:

"I think you had better produce the witness and lay the groundwork for the introduction of the summary so Mr. Ferleger can cross-examine and object."

I am not sure what customary business practices are and I don't believe an affidavit submitted to a Court can be considered a business record.

In addition, Mr. Roth's summary of the affidavit indicates that we have, by my count, a fifth level of hearsay in terms of this affidavit and the information that it presents. Also, the Court may recall that at an earlier hearing, I indicated that two cases in which I personally represented juveniles who objected were not listed in that summary. So that I, personally, know for a fact that the summary is not accurate or at least I have indications to that effect and I certainly could not agree it could go in.

I don't understand Mr. Roth suddenly presenting this affidavit when he knew that he needed testimony in support of his submission. I also don't see that it is relevant, whether regulations which are (299) challenged work or do not work or whether 20 juveniles object to admission, rather than 35 or 55, seems to me to be not really crucial to this case.

Mr. Roth already has testimony of Dr. Tashjian's about what happens at the Institute of the Pennsylvania Hospital and I have no idea what happens in the rest of the state. I don't believe this exhibit is any help at all, either.

THE COURT: What is the purpose of this exhibit, Mr. Roth? Why do you need it in the record?

MR. ROTH: Your Honor, the Commonwealth merely wishes to show that the regulations are being utilized and that juveniles who object at or subsequent to admission are being afforded hearings.

If Mr. Ferleger is willing to stipulate to that, certainly we will have no need to introduce this into evidence.

THE COURT: Mr. Ferleger is saying this may not be complete.

You are not saying, are you, Mr. Ferleger, that any part of this is inaccurate or correct? You are saying it is not complete; that there may be more cases than indicated in D-15?

MR. FERLEGER: Yes. D-15 indicates every child who objects is given a hearing when under (300) the regulations children may be released.

The cases I know involved children who were objecting and were released because the hospital decided not to go for a hearing and there are a number of cases which have notices as the facts.

I will stipulate a large number of institutions are using the regulations and a large number of juveniles who objected were given hearings. There is no question about that.

MR. ROTH: Mr. Ferleger has indicated that he has represented two clients who objected to institutionalization that are not on this list. Certainly, we are not apprised of that from any evidence being introduced.

MR. FERLEGER: If Dr. Phelleps was here I could examine him about whether he contacted the institutions that were involved in my cases and what their responses were.

It is indicated he got letters from the various places you have not submitted those letters. I have no idea what he is basing his affidavits on.

Your Honor, if I may, I think Mr. Roth is being a little overindulgent in saying that we need 300 witnesses. Mr. Roth could certainly submit to me the written responses from the institutions. He could (301) have done that months ago. He could have said that at the hearing a month ago when Judge Gibbons indicated he would have to bring the witness in.

MR. ROTH: Your Honor, may I?

THE COURT: Well, is there any—can Counsel agree on any of this?

In other words, hopefully, we are closing the record today. If there could be some agreement of some type,

it would be very helpful. I think there are technical problems as Judge Gibbons pointed out at the last hearing. Perhaps Judge Gibbons and Judge Broderick were not aware of the magnitude defendants would have to get this type of information into the record, and it seems that if defendants wish to get it into the record, somehow there should be a way of getting it in.

Is there any area of agreement by Counsel on D-15?

MR. FERLEGER: I don't believe so, your Honor. I understood that the defendant had foregone any further testimony in this case and I don't see that this affidavit is the basis for introducing the alleged facts that they want introduced.

MR. ROTH: Your Honor, we certainly did not, nor would we attempt to mislead your Honor and Mr. Ferleger with regard to our position—

(302) THE COURT: I am not concerned about that. I am sure you did not attempt to mislead anybody. Don't worry about that.

MR. ROTH: Thank you.

With regard to Mr. Phelleps, he can testify only to what is in the affidavit and I thought it would be more expeditious with providing you with the affidavit, indicating what he does in his customary business practice together with my understanding of the rules would be acceptable.

MR. FERLEGER: Mr. Phelleps has no personal knowledge of any of the facts that are in the exhibit which is the summary involved here. Mr. Phelleps sent letters to somebody else who sent them to somebody else and who

sent them to somebody else and it was delegated to a staff person and shipped up on the law.

I don't know if this was regular procedure. I don't know whether Mr. Roth wants evidence to prepare for litigation; whether Mr. Phelleps' normal job includes being an investigator for defendants' Counsel.

I don't believe this is a business record and I don't believe the facts in that summary can be admitted.

MR. ROTH: Your Honor, Mr. Phelleps has sworn in this affidavit to exactly what procedure (303) he generally utilizes in gathering and dispensing information and at my request, he gathered information regarding these regulations. Also, in accordance with the regulations, we had indicated to the public in the Pennsylvania Bulletin, that six months after publication of those records we would ascertain to see how they were working to determine whether or not we would hold public hearings.

So we respectfully request that this data be introduced into evidence and that Mr. Ferleger who does not seem to object to the accuracy as much as its completeness, if he would like to provide more information, certainly we would like to see that information and register if we have any objections to their introduction.

MR. FERLEGER: I don't know whether it is accurate. I know it is incomplete. I don't know how accurate it is.

THE COURT: Well, can Counsel agree that under the new regulations, there are juveniles, who at the time of admission did object and that petitions were then submitted and the patient was committed under Section 406 and this occurred at a number of the state hospitals

throughout the Commonwealth at various locations, as well as other types of institutions, such as private (304) mental hospitals?

MR. FERLEGER: Yes, your Honor.

MR. ROTH: I would be willing to stipulate—

THE COURT: Would this cover the situation?

MR. ROTH: Yes.

THE COURT: Would Counsel so stipulate?

MR. FERLEGER: Yes.

MR. ROTH: Yes, we shall.

THE COURT: Then there is no need to have D-15 admitted.

What else do you have?

MR. ROTH: With regard to our last exhibit, we wish to withdraw defendants' Exhibit 16, which was a summary of Dr. Sugar's pretrial deposition.

THE COURT: That is withdrawn. All right.

MR. ROTH: We have no other exhibits to introduce, your Honor.

THE COURT: Now, there are missing numbers, starting with D-8. There is no D-8 and D-9?

MR. ROTH: That's correct, your Honor.

THE COURT: May the record now be closed, gentlemen?

MR. FERLEGER: Yes, I just want to (305) mention, your Honor, something I gave your clerk this morn-

ing and Mr. Roth. At 9:15, in this morning's mail, your Honor, I received a copy of an opinion by the Supreme Court of Appeals in the State of West Virginia in a Habeas Corpus action, it is dated July 30, 1974, Hardway versus Flowers, and that Court ruled, a juvenile who is committed without a prior hearing and Counsel to a mental hospital, and it happened to be a very good mental hospital, according to the opinion, that that juvenile was denied due process and equal protection in her commitment.

The other matter I have, your Honor, is something that may have been overlooked in the transition from Judge Masterson to your Honor, and that is the motions to file a brief Amicus of the Youth Law Center in San Francisco. It was filed and Judge Masterson never entered an order on their request to file a brief and on behalf of them we move that be admitted.

THE COURT: Any objection, Mr. Roth?

MR. ROTH: I have no objection.

THE COURT: This is document 31 in the clerk's file, dated October 4, 1974, and it is a request to file brief on behalf of Youth Law Center and I will order now that this brief may be filed.

MR. FERLEGER: Thank you, your Honor.

One other matter which I am not certain (306) how the Court wishes to dispose of and that is that I was informed while I was writing my brief that the United States of America, through the Department of Justice in Washington, D.C., wishes to file an Amicus brief which was completed last week and I believe your clerk may now have more up-to-date information than myself; which will be filed with the Court today or tomorrow and I would

request at this time on behalf of the plaintiffs that the Department of Justice for the United States be given leave to file their brief.

THE COURT: Off the record.

(Discussion held off the record.)

THE COURT: Back on the record.

I will permit the filing of the brief by the United States Government through the United States Department of Justice and I understand such brief will be filed within the next day or two.

MR. FERLEGER: Thank you, your Honor.

I would like to discuss the briefing schedule. The notes of testimony will be filed shortly. The court reporter has done a good job in keeping current.

Do you wish to file a further brief on behalf of the plaintiff, Mr. Ferleger?

MR. FERLEGER: I do not anticipate filing any further legal argument unless some new cases come (307) down, but I would like to file proposed findings of fact and conclusions of law within, I would suggest, ten days to two weeks after the transcript is completed.

THE COURT: All right, I will permit you to file proposed findings of fact and conclusions of law within two weeks after the filing of the notes of testimony.

MR. FERLEGER: Thank you, your Honor.

THE COURT: How much time do you need, Mr. Roth?

MR. ROTH: Your Honor, we would like to reply to Mr. Ferleger's brief which we received Friday afternoon,

and also reply to the transcript with proposed findings of fact and conclusions of law. May we ask for ten days after receiving Mr. Ferleger's proposed findings of fact and conclusions of law?

THE COURT: Very well, you may have then ten days after Mr. Ferleger files his proposed findings of fact and conclusions of law to file a brief and whatever else you wish to file and I ask that you also file proposed findings of fact and conclusions of law.

MR. ROTH: Thank you, your Honor.

THE COURT: After the notes have been filed, we will put this down for oral argument before the three Judges. I think we need oral argument here.

(308) Anything else, gentlemen?

MR. FERLEGER: I just want to make clear that my understanding is that or my intention is that I will file my papers after receiving the notes of the evidentiary hearing and I don't expect to wait for this hearing on the evidentiary matters today, because I don't feel that is crucial.

THE COURT: Do you agree with that, Mr. Roth?

MR. ROTH: Yes, your Honor.

THE COURT: All we are concerned with today are the exhibits.

MR. ROTH: I have no problem with that.

THE COURT: You will file your brief within ten days after Mr. Ferleger files his latest brief.

MR. ROTH: Fine, your Honor.

THE COURT: All right, would one of you prepare an order to that affect? Who wishes to do that?

MR. FERLEGER: I will.

THE COURT: Anything else, gentlemen?

MR. ROTH: No, your Honor.

MR. FERLEGER: No, your Honor.

THE COURT: Thank you very much, gentlemen.

(309) Court is adjourned.

(Whereupon, at 10:55 a.m., Court was adjourned.)

DEFENDANTS' EXHIBIT NO. 1

QUESTIONNAIRE

Commonwealth of Pennsylvania

May 31, 1973

SUBJECT: Juveniles Admitted or Committed to MH/MR Facilities Under Sections 402, 403 and 406 of the MH/MR Act of 1966

TO: Regional Deputy Secretaries, MH and MR Commissioner

ATTENTION: Regional

FROM: William B. Beach, M.D., Deputy Secretary for Mental Health and Medical Programs

Edward Goldman, Commissioner for Mental Retardation.

THROUGH: Gregory Coleman, Deputy Secretary of Operations

The United States District Court for the Eastern District of Pennsylvania, relative to the case of Bartley v. Haverford State Hospital has ordered the Department of Public Welfare to obtain and submit to the Court the following information:

1) The names and addresses of all MH/MR facilities which provide inpatient care of juveniles (MH/MR institutions, private licensed MH/MR facilities, and psychiatric units not used primarily for emergency detention);

2) The number of juveniles admitted or committed under Sections 402, 403 and 406 of the MH/MR Act of 1966 during the calendar year 1972;

3) The number of juveniles in residence as of May 10, 1973, under Sections 402, 403 and 406,

4) Reason for juveniles' admission or commitment or precipitating behavior warranting admission or commitment;

5) Objection of admission or commitment and/or detention by juvenile patient;

6) Relationship of applicant;

7) Mental status, competency to make judgment at time of admission or commitment; and

8) A copy of each facility's admission policy.

Juvenile is defined as one who is 18 years or younger. In this case those who had reached their 18th birthday as of May 10, 1973 should be included. However, those turning 18 years of age prior to May 10, 1973 should not be included. If the individual is 18 years and one day, he is not considered to be a juvenile.

Enclosed is a form sheet with definitions outlining information required. Please send copies of this form to all facilities listed for your respective Region. For your information, we have enclosed a list of all those DPW facilities from which this information is required. Please note that we have obtained much of this information from the State Hospitals and State Schools and Hospitals. Therefore, you should only be concerned with all private licensed MH and MR facilities and those psychiatric units not used primarily for emergency detention.

It is absolutely necessary that this information be received in Central Office to the attention of Mr. Ralph

Phelleps, Office of Mental Health, Room 303, Health & Welfare Building, Harrisburg, Pennsylvania 17120 no later than July 2, 1973.

If there are questions, you may contact Mr. Phelleps at Telephone #787-5370 or Richard Barbush at Telephone #787-5102.

INFORMATION SHEET

Admission/Commitment of Juveniles

Definitions/Explanation

Juveniles—Those who are 18 years of age and younger. The individual is still considered a juvenile on his 18th birthday; however, when he becomes 18 and one day, he is no longer a juvenile but is considered an adult.

Number—Do not name the juvenile; use his or her case or file number.

Objection—We wish to know if the juvenile objected at his admission or subsequent thereafter to remaining in your facility. Indicate Yes or No or N.I. for not indicated in records.

Competency—Indicate only if juvenile objected, whether or not the juvenile had the mental capacity to make that judgment—Yes/No. If juvenile's behavior pattern causes him to be negative, indicate negative. If not revealed in chart, indicate N.I. for not indicated.

NAME OF FACILITY:

ADDRESS:

1. Number of Juveniles Admitted During Calendar Year 1972 Under

402 ————

403 ————

406 ————

If possible, indicate number of those remaining at end of year ————.

2. Number of Above That Were Readmissions

402 ————

403 ————

406 ————

3. List 402 Admissions By Case or File Number and Supply Appropriate Information.

Number; Reason for Admission/Behavior; Objection; Applicant/Relationship; Mental Capacity/Competency

CONTINUATION OF NUMBER 3. (List 402 Admissions by Case or File Number and Supply Appropriate Information).

Number; Reason for Admission/Behavior; Objection; Applicant/Relationship; Mental Capacity/Competency

4. List 403 Admissions By Case or File Number and Supply Appropriate Information.

Number; Reason for Admission/Behavior; Objection; Applicant/Relationship; Mental Capacity/Competency

CONTINUATION OF NUMBER 4. (List 403 Admissions By Case or File Number and Supply Appropriate Information).

Number; Reason for Admission/Behavior; Objection; Applicant/Relationship; Mental Capacity/Competency

5. List 406 Admissions By Case or File Number and Supply Appropriate Information.

Number; Reason for Admission/Behavior; Objection; Applicant/Relationship; Mental Capacity/Competency

CONTINUATION OF NUMBER 5. (List 406 Admissions By Case or File Number and Supply Appropriate Information).

Number; Reason for Admission/Behavior; Objection; Applicant/Relationship; Mental Capacity/Competency

6. Attach a copy of your Admission policy for juveniles and adults.

NOTE: For Numbers 3, 4, and 5, if more space is needed please attach extra sheets with appropriate headings.

DEFENDANTS' EXHIBIT NO. 4

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

HOSPITAL Haverford State Hospital

D . . . D . . .

Name
Case No. 10118 Page ———

ADMISSION NOTE: 3/1/73

D . . . D . . . , aged 14, admitted March 1, 1973, on a voluntary commitment to Bldg. #9. His previous behavioral history is complex, chaotic and has caused his family a great deal of concern and conflict. He has also been truant from school and he has refused to cooperate with out-patient psychotherapeutic attempts.

He is oriented in all spheres, he was initially uncooperative but eventually stated his opinion and limited understanding of his past behavior. There is a strong indication that he has a fragile hold on reality issues and seems relatively sad and confused.

Current plan is to admit him and see him as an individual patient and work separatedly at first with his parents. Plans are to use both male and a female therapist for D . . . . Defer competency as patient is not of age to drive.

IMPRESSION:

Adjustment reaction of adolescence.

Gus P. Kratsa, M.D.

cbw
RTS-112 not sent

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE
HOSPITAL Haverford State Hospital

Name D . . . D . . .
Case No. Page ———

Present: Drs. Kratsa, Armstrong and members of the Adolescent Service Staff.

NEW CASE CONFERENCE NOTE:

D . . . D . . . was admitted March 1, 1973. D . . . D . . . age 14 demonstrates a very difficult clinical problem. His outline in his admission note was referred for inpatient care by Dr. Bernard Kantor who felt that he was unmanageable as an out-patient and he was also chronically truant from school. During this hospital stay our plan is to someway initiate motivation toward a out-patient therapy and find a reasonable school that D . . . can evolve himself with for his future educational involvement. Our assessment of family process at this time is exceedingly pessimistic. Both of D . . . adopted parents have poor reserve both physically and emotionally and are in our opinion very likely unable to cope with the future demands that D . . . will make upon them upon discharge. We are therefore working very diligently towards a residential placement in a therapeutic facility similar to the Green Bank School which had been recommended to us by an outside consultant.

It was also important during this hospital stay to further assess D . . . neurologic status. Again we recommended that D . . . be evaluated by another neurologist in the community with currently completing his evaluation which will include a repeat of an EEG which was done here at Haverford and felt to be borderline.

DIAGNOSIS:

1. Multiple developmental deviation in multiple dimensions.

2. Unsocialized aggressive reaction of adolescence.

RECOMMENDATIONS:

We are recommending residential placement in a therapeutic school and continued psychotherapy for D . . . for an indefinite period of time. He is currently not cooperating with our program. He is not affectively accepting medication.

Gus B. Kratsa, M.D.

GBK/dmn.

DEFENDANTS' EXHIBIT NO. 5

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE
HOSPITAL Haverford State

Name M . . . A . . .
Case No. 9929 Page ———

ADMISSION NOTE

January 10, 1973

A . . . M . . . , age 15 years-10 months, referred from HUP following in-patient psychiatric evaluation. Had been in out-patient treatment at Hahneman prior to HUP admission. Current problem is difficult to assess without admitting A . . . for further observation. He is depressed and suicidal—has been especially pre-occupied with suicide, for the last few months.

Will be admitted to Building 4 with possible transfer to Building 9. Both parents and one of his 3 siblings were part of this evaluation.

(s) G. B. Kratsa
G. Kratsa, M.D.

1s

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE
HOSPITAL Haverford State Hospital

Name M . . . A . . .
Case No. 9929 Page ———

NEW CASE CONFERENCE NOTE:

Present: Drs. Armstrong, Kratsa and members of the Adolescent Service.

A . . . M . . . , age 15 was admitted on January 10, 1973 following a transfer from the University of Pa. Hospital Psychiatric Unit. Please refer to the summary of his hospital admission for details of that admission and the reason regarding his transfer to our facility. On admission A . . . was cooperative, demonstrated slurred speech secondary to a great deal of over-medication. The medication was felt to be indicated in order to facilitate his transfer from the Hospital of the University of Pa. to Haverford State Hospital. At the time of admission A . . . was on Tofranil 50 mgm t.i.d., Thorazine 25 mgm t.i.d., Valium 5 mgm b.i.d., Tylenol 2 tablets q 4 hrs. prn headache. Following a review of the clinical material from the Hospital of the University of Pa. including a medical evaluation for Cushings Disease, it was our opinion that a further neurologic consultation was indicated. This was accomplished and at the time of this dictation it was the opinion of the consulting neurologist that there was no underlying neurological disease and A . . . problem was indeed primarily psychiatric. A psychological testing which was completed prior to the time of this dictation demonstrated a very limited capacity in many spheres including ego strength,

academic skills and overall personality development. Our goals relative to his education were therefore set with minimal demands and he was assigned to the small tutoring group rather than the day school. Gradually all medication was discontinued and he was then placed on a small amount of Stelazine at bedtime along with Cogentin and was given prn analgesics for a continued complaint of tension headaches. The plan during the hospital stay was to facilitate his return to his family and to complete his full year with the Haverford Day School Staff.

DIAGNOSIS:

Adjustment reaction of adolescence with depressive features and intellectual limitations and poor impulse control.

(s) G.B. Kratsa
Gus Kratsa, M.D.

GK/dmn.

OPINION—JULY 24, 1975

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

Civil Action No. 72-2272

Kevin Bartley, et al.

vs.

Jack B. Kremens, individually and as Hospital Director of Haverford State Hospital, et al.

Before Honorable John J. Gibbons, Circuit Judge, and Honorable Daniel H. Huyett, 3rd, and Honorable Raymond J. Broderick, District Judges

HUYETT, J., July 24, 1975:

OPINION AND ORDER

Plaintiffs have filed this class action[1] on behalf of the named plaintiffs and all persons eighteen years of age or younger who have been, are, or may be admitted or committed to mental health facilities in Pennsylvania under the

[1] On April 29, 1974, we ordered that this action be maintained as a class action but left open the possibility that the definition of the class set out in the text might be amended or altered before the decision on the merits. We now find that this definition of the class is appropriate. We note that this action concerns children who allegedly are mentally ill as well as children who allegedly are mentally retarded.

Pennsylvania Mental Health and Mental Retardation Act (Act). 50 P.S. §§4402 and 4403 (§§402 and 403).[2]

[2] Section 402 of the Pennsylvania Mental Health and Mental Retardation Act of 1966 provides in part:

> Section 402. Voluntary admission; application, examination and acceptance; duration of admission.
>
> (a) Application for voluntary admission to a facility for examination, treatment and care may be made by:
>
> (1) Any person over eighteen years of age.
>
> (2) A parent, guardian or individual standing in loco parentis to the person to be admitted, if such person is eighteen years of age or younger.
>
> (b) When an application is made, the director of the facility shall cause an examination to be made. If it is determined that the person named in the application is in need of care or observation, he may be admitted.
>
> (c) Except where application has been made under the provisions of Section 402(a)(2) and the person admitted is still eighteen years of age or younger, any person voluntarily admitted shall be free to withdraw at any time. Where application has been made under the provisions of Section 402 (a)(2), only the applicant or his successor shall be free to withdraw the admitted person so long as the admitted person is eighteen years of age or younger.

Section 403 of the Pennsylvania Mental Health and Mental Retardation Act of 1966 provides in part:

> Section 403. Voluntary commitment; application, examination and acceptance; duration of commitment.
>
> (a) Application for voluntary commitment to a facility for examination, treatment and care may be made by:
>
> (1) Any person over eighteen years of age.
>
> (2) A parent, guardian or individual standing in loco parentis to the person to be admitted, if such person is eighteen years of age or younger.
>
> (b) The application shall be in writing signed by the applicant in the presence of at least one witness. When an application is made, the director of the facility shall cause an examination to be made. If it is determined that the person named in the application is in need of care or observation, he shall be committed for a period not to exceed thirty days. Successive applications for continued voluntary commitment may be made for successive periods not to exceed thirty days each, so long as care or observation is necessary.
>
> (c) No person voluntarily committed shall be detained for more than ten days after he has given written notice to the director of his intention or desire to leave the facility, or after the applicant or his successor has given written notice of intention or desire to remove the detained person.

Invoking 28 U.S.C. §§1331 and 1343(3) and 42 U.S.C. §1983, plaintiffs ask us to declare §§402 and 403 unconstitutional and enjoin their enforcement.[3]

Plaintiffs contend that in violation of the Fourteenth Amendment to the United States Constitution, they are being denied both due process of law and equal protection of law because Pennsylvania allows plaintiffs and their class to be detained—denied their liberty—in mental institutions without substantial procedural safeguards including the: (1) right to notice; (2) right to a pre-commitment hearing; (3) right to counsel and if indigent appointment of counsel; (4) right to present evidence on

[3] Plaintiffs do not challenge either Section 405 or 406 of the Pennsylvania Mental Health and Mental Retardation Act of 1966. Section 405 permits involuntary detention of persons, regardless of age, under emergency conditions for no longer than 10 days. Section 406 permits involuntary commitment of persons upon petition to the state court of common pleas and after hearing and examination. The person to be committed is entitled to notice of hearing, the right to counsel, and the opportunity and right to present testimony and evidence in his or her behalf and to confront his or her accusers. The court may order outpatient or partial hospitalization instead of in-hospital commitment.

their own behalf; (5) right to subpoena witnesses and documents; (6) right to confront and cross-examine witnesses against them and those who wish to admit or commit them; (7) right to be involuntarily detained only upon a decision of a judicial officer; (8) right to be involuntarily detained only upon a decision that they are in need of treatment, care, or observation.[4] Plaintiffs also contend that the regulations supplementing §§402 and 403 do not cure these sections of their constitutional infirmities because they apply only to children 13 years of age or older, require no pre-commitment hearing, and designate no time by which a post-commitment hearing must be held.[5] In essence, plaintiffs claim that the present procedures do not adequately assure against the mistaken commitment of children who are not mentally ill.

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[4] We are not presented with the issue of what standards are needed for commitment. For an analysis of this question see the recent opinion of J. Hoffman in *Commonwealth ex rel. Charles Finkin, Jr. v. Roop,* Pa. Superior Ct. (1975). Also see, *Bell v. Wayne County,* 384 F. Supp. 1085, 1095 (E.D. Mich. 1974).

[5] After plaintiffs filed this action the Department of Public Welfare, pursuant to Section 201(2) of the Pennsylvania Mental Health and Mental Retardation Act of 1966, adopted additional procedural safe-guards for children admitted or committed to institutions pursuant to Sections 402 and 403. These regulations provide in part:

1. All juveniles age 18 and younger to be admitted to an Institution must be referred from a recognized medical facility Mental Health/Mental Retardation therapist or Mental Health Agency; however, mentally retarded juveniles may be referred by either a pediatrician, or general physician or psychologist;

2. This referral must be accomplished by a psychiatric evaluation and that report must indicate with specificity the reasons that the person requires institutional care; however, a medical or psychological evaluation may accompany the referral of a mentally retarded juvenile;

3. The Director of the Institution or his delegate, shall have conducted an independent examination of the proposed juvenile, and if his results disagree with the professional's opinion, the Director, or his delegate shall discharge the juvenile;

4. The telephone number and address of the juvenile's parents or the person who is requesting admission for the juvenile must accompany the referral;

5. Within 24 hours after the juvenile's admission, every youth who is at least 13 years of age must receive written notification (which he signs) explaining his rights indicating that he will be given a status report periodically of his condition; that he can contact by telephone or by mail his parents or the person who requested his admission; and that he will be furnished with the number of counsel (Public Defender's number; Legal Services) that he can call for representation. An appropriate person shall explain this notice (attached);

6. In the event that a juvenile whose chronological age is 13 or older objects (either orally or in writing) to remaining in the Institution, the Director, or his delegate, if he feels it is necessary for the youth to remain, may continue the institutionalization for two business days during which time he shall notify the applicant and the referral unit so that either party may institute a 406 proceeding. During that same two-day period, the Director, or his delegate, shall notify the Public Defender's Office or notify Legal Services readily available of the juvenile's need for legal representation. If a 406 proceeding is begun during the two-day period, the juvenile shall remain institionalized. If the applicant cannot be located and the Director, or his delegate, feels that the juvenile does not require institutionalization, the Director, or his delegate, shall direct the Base Service Unit to assume responsibility of providing for the juvenile's aftercare. However, if the Director, or his delegate, feels that the juvenile requires institutionalization, he shall direct the Base Service Unit to

In support of their claim that §§402 and 403 are unconstitutional, plaintiffs have submitted brief summaries of the reasons for the commitment of the named plaintiffs and other members of their class to demonstrate that many decisions to commit involve factual determinations requiring substantial procedures to guard against wrongful or erroneous commitment. We rely for our findings on the summaries contained in the final pretrial order which have been stipulated to and on defendants' exhibit numbered eight (8).

The named plaintiffs were either admitted under §402 or committed under §403 to Haverford State Hospital.[6] Plaintiff M.W. was admitted to Haverford State

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file a 406 proceeding within two days after failure to locate the applicant;

7. The juvenile's counsel shall be furnished with the juvenile's evaluation from the referral unit, with a psychiatric evaluation from the Institution, and with a written report of the reasons to institutionalize the juvenile;

8. If the staff member of the facility giving notice to the patient determines that the patient is incapable of understanding the notification, it shall be written on the notification;

The regulations do not provide a time by which a commitment hearing must be held. The Attorney General of Pennsylvania assures us that in cases involving children at least 13 years of age, commitment hearings are scheduled within a short while after the child objects. With respect to children 12 years of age or younger, there is no requirement for a hearing, no less a designated time. Defendants submit that these regulations were not adopted with and towards this litigation and that with or without them, Sections 402 and 403 are constitutional.

[6] By stipulation Haverford State Hospital was withdrawn as a defendant. Haverford is a mental health "facility" under Section 102 P.S. §4102 of the Mental Health and Mental Retardation Act. It receives admissions and commitments of persons including persons eighteen years of age or younger admitted or committed under Sections 402 and 403.

Hospital under §402(a)(2). His mother admitted him allegedly against his wishes when he was fifteen and on December 1, 1972, he informed agents and employees of defendant of his desire to leave Haverford State Hospital. Plaintiffs K.B., S.G., L.L., and V.M. were committed to Haverford State Hospital under §403(a)(2). Plaintiff K.B. was fifteen when his mother committed him against his wishes. He was and still is critical of some of the hospital's regulations and treatment practices. Plaintiff S.G. was seventeen when his father committed him allegedly against his wishes. Plaintiff L.L. was fifteen when her mother committed her allegedly against her wishes. Her difficulties in relating to her mother resulted in her commitment. Hospital records show that she threatened the lives of her mother and sister and that she has a personality disorder. Her parents are divorced and her father is remarried, living in Florida. At the time of her commitment and the time this action was filed, she would have preferred to have been with her father and when she is with him her behavior is excellent. Plaintiff V.M. was fourteen when her mother committed her allegedly against her wishes.

Members of plaintiffs' class have been institutionalized for various other reasons. Patient number 13,173, a moderately retarded 13 year old child, was institutionalized in Polk State Hospital because of very sudden, explosive, rage reactions during which he attacked others and of which he has no recollection. His behavior rather than his mental retardation was the primary obstacle to his return to the community. Patient number 13,212, an

educable mongoloid boy with the capacity to participate in many educable and trainable activities and who can be helped by an active special elementary program in public schools, was institutionalized in Polk State Hospital for a 1 to 2 week period so that the other members of his family could go on a family vacation. Patient number 288, a mentally retarded child, was placed in Western State Hospital because of a poor family situation. The mother of the child did not get along well with the child, and the family was afraid that she would have another nervous breakdown if the child were not placed in Western State Hospital. Patient number 281, a mentally retarded child, was placed in a state institution because she had become a management problem to both her parents and the community. Patient number 15, a mentally retarded child, was placed in Western State Hospital because the child interfered with the routine of the household and disturbed family members. The placement was based on a fear that if the child remained in his home, the mother might break down, the marriage of the child's parents might end in separation, the father's health might fail, and an adolescent daughter might be pushed into a premature marriage to escape an unhappy home. Class members have also been committed to mental hospitals for running away, robbing a gas station, stealing in general, chasing and striking a girl, arson, delinquent behavior in general, truancy, physical ailments such as colitis and weight loss, school phobia, and drug overdose.

At the time this action was filed defendants were all Pennsylvania officials with specific duties under the Act. Defendant Jack B. Kremens as Hospital Director of Haverford State Hospital was charged under 50 P.S. §§4102 and 4203 with supervision and administration of Haver-

ford State Hospital. It was to Kremens or his delegates that application for admission and commitment under §§402(b) and 403(b) of the Act had to be made. Defendant Helene Wohlgemuth as Secretary of Public Welfare of the Commonwealth of Pennsylvania (Secretary) had the power under 50 P.S. §§4201 and 4202(a) to enforce the Act, to make all regulations necessary and appropriate to the proper accomplishment of the Act, and to operate and assign functions to all state facilities. Defendant William B. Beach as the Deputy Secretary for Mental Health and Mental Retardation of the Department of Public Welfare of the Commonwealth of Pennsylvania had the general authority to supervise and regulate mental Health facilities in Pennsylvania.

At the outset, defendants contend that since the purpose of the Act is to meet the child's needs through treatment and rehabilitation rather than to punish the child by incarceration for what he has done, the requirements of due process do not apply to the institutionalizing of children under §§402 and 403.[7] Defendants proceed to argue

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[7] A number of defendants in similar cases have raised this argument. In *In re Gault*, 387 U.S. 1, 21 (1966), defendants claimed that juveniles obtain benefits from the informal juvenile procedures which more than offset the disadvantages of denying them the substance of normal due process. The Court rejected this argument holding:

> observance of due process standards, intelligently and not ruthlessly administered, will not compel the States to abandon or displace any of the substantive benefits of the juvenile process.

In *Denton v. Commonwealth*, 383 S.W. 2d 681 (Ky. 1964), cited approvingly by Judge Biggs in *Dixon v. Attorney General of Pennsylvania*, 325 F. Supp. 966, 972 (M.D. Pa. 1971), the court also rejected this argument holding that commitment procedures should

that if we determine that due process applies, we should find that in light of Pennsylvania's interest in protecting the child, preserving the family unit, maintaining the rights of parents to the custody, care, and upbringing of their children, and protecting society, the present statutes and

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be the same in civil commitment proceedings as they are in criminal proceedings. Responding to this same argument, Judge Biggs in *Dixon* stated: "We are unimpressed by the parens patriae argument and strong courts have not been persuaded by it." (Citations omitted.) In *Holm v. State*, 404 P.2d 740, 742 (Wyo. 1965) the Wyoming Supreme Court held:

> No matter how commendable the motives back of legislation for the mentally ill may be it still remains the fundamental law of the land that a person is not to be deprived of his liberty—whether by involuntary hospitalization or some other kind of incarceration—without due process of law.

In *Heryford v. Parker*, 396 F.2d 393 (10 Cir. 1968), the court held that even if the institutionalizing of children is for rehabilitation, the constitutional safeguards of due process must be observed. The court in *Lessard v. Schmidt*, 349 F. Supp. 1078 (— Wis. 1972), was faced with the argument that due process procedures should be relaxed because of a subsequent right to treatment and because the commitment proceedings were civil in nature. After examining the effect civil commitment may have on those adjudged mentally ill, the court rejected these arguments and held that all persons 18 years of age or older being held pursuant to any emergency, temporary, or permanent commitment provision of the Wisconsin involuntary commitment statute, were entitled to substantial procedural safeguards. *Saville v. Treadway*, F. Supp. (M.D. Tenn. 1974) presented a challenge to a Tennessee Statute which permitted the "voluntary" commitment of juveniles by a parent, guardian, or person having legal custody of a mentally retarded minor. While recognizing the services furnished to mentally retarded children by the state, and the efforts in mental rehabilitation of the state, the court held that "where individual liberty is at stake . . . it is absolutely essential that such confinement be preceded by adequate procedural safeguards."

regulations satisfy any due process requirements. Finally, defendants argue that since under §§402 and 403 the parents, guardians ad litem, or persons standing in loco parentis must set into motion the commitment machinery, these persons effectively waive any due process rights of plaintiffs and their class.

DISCUSSION

Under the constitutional guarantee of procedural due process, we have developed a system whereby a person who may be subjected to a grievous loss of liberty is entitled to adequate procedural safeguards. *Wolff v. McDonnell*, 418 U.S. 539 (1974). Generally, the state is required to provide substantial procedures when there is the possibility of erroneously and wrongfully depriving persons of their liberty by committing them to mental institutions. See, concurring opinion of Chief Justice Burger in *O'Connor v. Donaldson*, 43 U.S.L.W. 4929, 4935 (1975); *Lynch v. Baxley*, 386 F. Supp. 378 (M.D. Ala. 1974); *Lessard v. Schmidt*, 349 F. Supp. 1078, remanded 414 U.S. 473 (1974); redecided 379 F. Supp. 1376 (1974), remanded 43 U.S.L.W. 3600 (May 12, 1975); *Dixon v. Attorney General Commonwealth of Pennsylvania*, 325 F. Supp. 966 (M.D. Pa. 1971). These safeguards attempt to protect persons from an arbitrary or erroneous deprivation of liberty or property, whether that deprivation be imposed for benevolent or punitive reasons. They are "our best instruments for the distillation and evaluation of essential facts from the conflicting welter of data that life and our adversary methods present." They "enhance the possibility that truth will emerge from the confrontations of opposing versions and

conflicting data." *In re Gault,* 387 U.S. 1, 21 (1966). As Mr. Justice Frankfurter has said: "The history of American freedom is, in no small measure, the history of procedure." *Malinski v. New York,* 324 U.S. 401, 414 (1945) (separate opinion) cited by the majority in *In re Gault,* at 21. If we are to preserve our traditional liberty we must scrutinize with care any claim that it is being arbitrarily denied.

In deciding whether the requirements of due process apply in any given case, the threshold question is whether the interest of the complaining party is within the contemplation of the liberty or property language of the Fourteenth Amendment. *Morrissey v. Brewer,* 408 U.S. 471, 481 (1971). The particular question here is whether or not a child's interest in not being institutionalized under §§402 and 403 is safeguarded by the Fourteenth Amendment. Defendants would have us find that because Pennsylvania is acting as parens patriae and not as an adversary, and because the admission and commitment proceedings are civil, not criminal, in nature, plaintiffs and their class may not complain of the deprivation of procedures available in criminal cases. Such a finding would ignore that the child is involuntarily removed from his home and familiar surroundings and is committed to an institution where "[he] suddenly faces the regimented routine of ward life and daily confrontation with state employees, however capable, rather than family and friends." *In re Ballay,* 482 F.2d 648, 669 (D.C. Cir. 1973). As the Court of Appeals for the Tenth Circuit noted in *Heryford v. Parker,* 396 F.2d 393, 396 (1968):

> It matters not whether the proceedings be labeled "civil" or "criminal" or whether the subject matter be mental instability or juvenile delinquency. It is the likelihood of involuntary incarceration whether for punishment as an adult for a crime, rehabilitation as a juvenile for delinquency, or treatment and training as a feeble-minded or mental incompetent—which commands observance of the constitutional safeguards of due process.

Defendants' contention also ignores the stigma associated with civil commitment which some commentators and courts have noted may render civil commitment a more lasting abridgement of personal freedom than imprisonment for commission of a crime.[8] The child who faces

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[8] Loss of liberty is in issue not only when a person is physically confined. The Due Process Clause also affords protection "where a person's good name, reputation, honor, or integrity is at stake because of what the government is doing to him." *Wisconsin v. Constantineau,* 400 U.S. 433, 437 (1971); *Board of Regents v. Roth,* 408 U.S. 564, 573 (1972); *Goss v. Lopes,* 419 U.S. 565 (1975); *Donalds v. O'Connor,* 493 F.2d 507, 520 (5 Cir. 1974), vacated and remanded *O'Connor v. Donaldson,* 43 U.S.L.W. 4929 (1975).

While we hope that society is moving in the direction of viewing mental illness in the same light as physical illness, we cannot ignore the reality that many in our society view mental illness with disdain or apprehension. See *In re Ballay,* 482 F.2d 648, 668 (D.C. Cir. 1973), where the court noted that, "[e]ven accepting recent medical advances, current studies clearly indicate the fallacy of contending that most people view mental illness as a disease similar to any physical ailment of the body" and that it could not "ignore the striking example of this attitude displayed by news stories and public reaction to disclosures made by a recent vice-presidential aspirant." In *Pennsylvania Association for Retarded Children v. Commonwealth of Pennsylvania,* 343 F. Supp. 279, 293 (E.D. Pa. 1972), Judge Masterson, writing for the three judge court, held that in light of *Wisconsin v. Constantineau, supra,* due process requires a hearing before retarded children may be denied a public education because of the stigma which our society unfortunately attaches to the label of mental retardation.

the possibility of being physically confined for an indeterminate period with all of the ramifications of such confinement clearly has an interest within the contemplation of the liberty and property language of the Fourteenth Amendment.

Having decided that due process applies, we are left with the questions of what process is due, *Morrissey v. Brewer, supra,* at 481 and whether this process may effectively be waived by plaintiffs' parents, guardians ad litem, or persons standing in loco parentis.[9] Before discussing the process here, we shall first consider whether or not parents, guardians ad litem, or persons standing in loco parentis may effectively waive the personal rights of children, since such a finding obviates the need to decide whether the present procedure violates the constitutional right of plaintiffs to procedural due process. The question is both difficult and unique. Viewing the issue as whether or not a parent may effectively waive personal rights of a child when the child objects to the waiver creates a confrontation between a liberty interest of plaintiffs we find constitutionally protected and the consistently recognized authority of parents to direct the rearing of their children. *Ginsberg v. New York,* 390 U.S. 629, 639 (1968).

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[9] As yet, the Supreme Court has not decided whether the child's parent, acting on behalf of the child, may effectively waive constitutional rights of the child. In *Heryford v. Parker, supra,* the court, in holding that the Due Process Clause applies to an involuntary civil commitment procedure, recognized that special problems may arise with respect to the effective waiver of rights by minors and mentally deficient persons. Finding that there was no express attempt to make such a waiver, the court did not decide the issue.

We presume that in most instances parents, proceeding in utmost good faith, acting for the child, in the child's best interests, properly guide, protect, and control their children. In *Wisconsin v. Yoder,* 406 U.S. 205, 231, 232 (1971), the Supreme Court, stating that it was not determining the proper reconciliation of possible competing interests of parents, children, and the state, noted that:

> The history and culture of Western civilization reflect a strong tradition of parental concern for the nurture and upbringing of their children. This primary role of the parents in the upbringing of their children is now established beyond debate as an enduring American tradition.

Also, see, Justice Stewart's concurring opinion at 237. We are not unmindful of this tradition and its importance to the structure of our society, *Ginsberg* at 639, and if we could find that in all instances parents act in the best interest of their children, we might also find that parents may waive constitutional rights of their children. Unfortunately, as such a graphic example as parental child abuse illustrated,[10] this is not the case.[11] In deciding to

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[10] See Memorandum and Order of Judge Urbom filed June 4, 1974, in *Horacek, etc., v. Exon, et al.,* Civil Action No. 72-L-299 (D.C. Neb. 1974). The claim before Judge Urbom was that the named plaintiffs were in a state hospital because their parents put them there. Responding to the argument that plaintiffs were in the hospital voluntarily because their parents placed them there, Judge Urbom held that "parents cannot deprive their children of constitutional rights—rights of the children vis-a-vis the state."

[11] Dissenting in *Kent v. United States,* 401 F.2d 408, 416, n.4 (D.C. Cir. 1968), the now Chief Justice Burger noted:

> Lawmakers in recent years have been sensitive to the need to make civil commitment difficult recognizing the dan-

institutionalize their children, parents, as well as guardians ad litem or persons standing in loco parentis, may at times be acting against the interests of their children. With this in mind we must agree with Judge Judd in *New York State Association for Retarded Children,* 357 F. Supp. 752, 762 (E.D.N.Y. 1973), that, "in the absence of evidence that the child's interests have been fully considered," parents may not effectively waive personal constitutional rights of their children.[12]

Remaining is the question of what process is due. Due process is flexible in that a determination of what process is due cannot be made without an evaluation of "the precise nature of the government function involved as well as of the private interest that has been affected by government action." *Cafeteria Workers Union v. McElroy,* 367 U.S. 886, 895 (1961). At a minimum, it requires that "deprivation of . . . liberty . . . by adjudication be

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gers of relatives "farming" out their kindred into mental institutions for motives not always worthy.

In *New York State Association for Retarded Children, Inc. v. Rockefeller,* 357 F. Supp. 752, 762 (E.D.N.Y. 1973), the court stated:

> [t]here may be a fundamental conflict of interest between a parent who is ready to avoid the responsibility of caring for an abnormal child, and the best interests of the child. Murdock [Civil Rights of the Mentally Retarded: Some Critical Issues], 48 Notre Dame Lawyer at 139-143.

[12] This finding does not mean that when considering whether or not to institutionalize a child, the state should ignore the opinions and observations of the child's parents. Rather, the committing authorities should listen carefully to parents who live with and observe the child on a daily basis for they very likely have invaluable information concerning their child.

preceded by notice and opportunity for hearing appropriate to the nature of the case,"[13] but the formalities of the procedure however, "the timing and content of the notice and the nature of the hearing will depend on appropriate accommodation of the competing interests involved."[14] Because courts cannot determine what process is due without evaluating the competing interests, the content of due process shifts as the interests shift; "[t]he required degree of procedural safeguards varies directly with the importance of the private interest affected and the need for and usefulness of the particular safeguard in the given circumstances and inversely with the burden and any other adverse consequences of affording it."[15]

As previously discussed, plaintiffs' interest in being free from the wrongful and unwarranted deprivation of their liberty is substantial and they argue that the present procedure does not adequately protect this interest. The state's interests are three fold. It has an interest in the mental health of children (parens patriae), an interest in preserving the family unit and maintaining parental authority over children, and an interest in confining, for the protection of society those persons who pose significant danger to the community (police power). The state has decided that its interests require a relaxed, informal procedure, and it argues that a more formal procedure will substantially interfere with its interests. To strike a proper

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[13] *Goss v. Lopez,* 419 U.S. 565, 79 (1975), citing *Mullane v. Central Hanover Trust Co.,* 339 U.S. 306, 313 (1950).

[14] *Goss v. Lopez,* at 579, citing *Cafeteria Workers v. McElroy,* 367 U.S. 886, 895 (1961); *Morrissey v. Brewer, supra,* at 481.

[15] See, Friendly, J. "Some Kind of Hearing", 123 U. Pa. L. Rev. 1267, 1278 (1975).

balance between the competing interests of plaintiffs and the state, we shall analyze them in the context of each procedural right of which plaintiffs claim they are being deprived. This will give us the content of the process which, at a minimum, is due before plaintiffs may be institutionalized for treatment.[16]

PRE-COMMITMENT HEARING

A decision to institutionalize a child is often a difficult yet necessary decision for a child's parent to make. It is generally pursued only after all other alternatives have proven futile. The state has an interest in seeing that a procedural system will not deter parents, already faced with this difficult decision, from attempting to institutionalize children who are in need of treatment only mental institutions can provide. Further, to protect society and the individual child, the state has an interest in the immediate detention of children who may be dangerous

[16] As we have already noted, due process is flexible; the Constitution mandates no specific code of procedures. We are aware of the problems facing courts when they attempt to fashion procedures protecting interests within the liberty and property language of the Fourteenth Amendment and we are sensitive to the claim that courts are "good at deciding cases, bad at drafting legislation. . . ." See, Friendly, J. "Some Kind of Hearing", supra. When presented with claims of constitutional dimension, however, we are constrained, when legislative bodies have failed to act, to find means of enforcing the constitutional rights being denied. Our action is not intended to pre-empt the state which is free to develop its own safeguards so long as they are as fully effective as those which we set out. See *Miranda v. Arizona*, 384 U.S. 436, 490 (1966); *Morrissey*, at 490.

to themselves or others. See, *Lessard v. Schmidt*, at 1092; Developments in the Law—Civil Commitment of the Mentally Ill, 87 Harv. L. Rev. 1190, 1275 (1974).

Balancing these substantial interests of the state with that of the child, we find that plaintiffs are not entitled to a pre-commitment hearing. As the Supreme Court has found with criminal cases, however, we find that, for the protection of the child, he is entitled to a hearing before an unbiased tribunal within a reasonable time to test whether there is probable cause to believe institutionalization is necessary. *McNabb v. United States*, 318 U.S. 332, 343-344 (1943); *Morrissey v. Brewer*, at 489 (1971); *Lynch v. Baxley*, at 388. In no event shall detention of the child in the absence of a probable cause hearing exceed seventy-two (72) hours from the date of the initial detention. See, *Lynch v. Baxley*, at 388; *Lessard v. Schmidt*, at 1091.[17]

POST-COMMITMENT HEARING

If the conclusion of the preliminary hearing is that there is probable cause for believing the child needs institutionalization, the child is entitled to a post-commitment hearing before an unbiased tribunal on the need for commitment. A delay after the probable cause hearing is permissible. This delay will allow the child to adjust

[17] In *Lynch v. Baxley*, at 388, the court held that emergency detention without a hearing on its appropriateness may not, in the absence of a probable cause hearing, exceed seven (7) days from the date of the initial detention. In *Lessard v. Schmidt*, at 1091, the court held that a probable cause hearing must be held within forty-eight (48) hours from the date of the initial detention.

to his new surroundings and will allow both the state and the child time to prepare for the post-commitment hearing to come. It will also allow the state time to examine and diagnose the child adequately. These reasons do not, however, justify a prolonged period of confinement without a final determination on the need for institutionalization and should not exceed a two-week period. A two-week period will afford all parties an opportunity to prepare adequately and properly their positions with hope of ascertaining that which is best for the child.[18]

NOTICE

The opportunity to be heard is fundamental to due process of law. *Grannis v. Ordean,* 234 U.S. 385, 394 (1914). Without notice of that which is to transpire at a hearing "sufficiently in advance of any required hearings so that reasonable opportunities to prepare will be afforded," *In re Gault,* at 33; *Lessard v. Schmidt,* at 1092; *Lynch v. Baxley,* at 388, the right to be heard has little significance. *Mullane v. Central Hanover Tr. Co.,* at 314. To counterbalance this substantial interests of plaintiffs the state argues that by delaying treatment and traumatizing the child, the requirement of notice will aggravate the child's mental illness, interfere with the state's police power, and disrupt family harmony. In *Gault* at 21, the Supreme Court refused to accept the state's fear of trauma

[18] Until the legislature acts to establish an unbiased tribunal to conduct the probable cause and final hearings the present facilities of the Commonwealth court system shall be used for these hearings.

as a justification for limited procedures. The Court stated that the observance of due process standards will not necessarily compel the states to abandon the substantive benefits of the juvenile process. Further, as Judge Tamm noted in *In re Ballay,* 482 F.2d 648, 664 (D.C. Cir. 1973), the fear that added procedural requirements will produce trauma presupposes that the person who faces commitment is mentally ill. Likewise, while procedural safeguards assume that not all persons who face commitment need actually be committed, the argument that procedures will interfere with the state's police power and disrupt family harmony assumes that the child is dangerous to others and comes from a family in harmony.

Keeping in mind that due process assures against error, we find written notice required, including the date, time, and place of the hearing, and a statement of the grounds for the proposed commitment. See, *Lynch v. Baxley,* at 388; *Lessard v. Schmidt,* at 1092. Neither the state nor plaintiffs have an interest in committing to mental institutions children not in need of institutionalization. Notice should not shield children in need of institutionalization from commitment and treatment but rather should protect children not in need of institutionalization from wrongful commitment and improper deprivation of their liberty.[19]

[19] Obviously this notice may be meaningless to some children. We, therefore, find that until some other procedure is established this notice shall be sent not only to the child but also to the Clerk of the Court with jurisdiction and shall be forwarded to the child's attorney. The child's attorney shall be in receipt of the notice at least forty-eight (48) hours prior to the initial hearing.

COUNSEL

The state fears that assistance of counsel will make institutionalization proceedings adversarial adding to the delay in treatment of the child and increasing the danger of trauma already inflicted by notice and a hearing. Yet the spectre of this particular trauma pales beside the spectre of the trauma inflicted on a child erroneously committed.[20] Notice and the opportunity to be heard may be of little value without the assistance of counsel. *Argesinger v. Hamlin,* 407 U.S. 25, 31 (1972); *Powell v. Alabama,* 287 U.S. 45, 68-69 (1932). A child whose liberty is in question "needs the assistance of counsel to cope with problems of law, to make skilled inquiry into the facts, to insist upon regularity of the proceedings, and to ascertain whether he has a defense and to prepare and submit it." *Gault,* at 36. As the right to counsel applies to

[20] The possibility and danger of error is discussed by D. L. Rosenhan in "On Being Sane in Insane Places," 179 Science 250 (1973). The article describes an experiment in which eight sane persons gained admission to twelve different hospitals and behaved normally. Their sanity was never discovered. Not only was their sanity not detected, but the psychodiagnostic label placed on the individual patients was never removed. According to Professor Rosenhan this error apparently resulted from what statisticians call type two error—error resulting from a Doctor's inclination to call a healthy person sick rather than a sick person healthy because it is more dangerous to misdiagnose illness than health.

Rosenhan suggests that the initial labelings color others' perception of the patient and eventually the patient himself accepts the diagnosis, with all of its connotations and expectations, and behaves accordingly. He also notes that there is substantial evidence that attitudes towards the mentally ill are characterized by fear, hostility, aloofness, and dread.

criminal cases, so it must apply during all significant stages of the commitment process, and plaintiffs must be informed of both their right to counsel and if indigent their right to appointment of free counsel. See, *In re Gault,* at 41; *Heryford v. Parker,* at 397; *Dixon v. Attorney General,* at 966; *Lessard v. Schmidt,* at 1097; *Lynch v. Baxley,* at 389; *United States v. Wade,* 388 U.S. 218, 226-27 (1967); *In re Barnard,* 455 F.2d 1370, 1375-76 (D.C. Cir. 1971); *Sarzan v. Gaughan,* 489 F.2d 1076, 1083-84 (1 Cir. 1973).

PRESENCE OF PERSON

In *Specht v. United States,* 386 U.S. 605, 610 (1967), the Supreme Court held that commitment proceedings under the Colorado Sex Offenders Act, whether denominated civil or criminal, are subject to the Due Process Clause of the Fourteenth Amendment and that due process requires that the person to be committed "be present with counsel, have an opportunity to be heard, be confronted with witnesses against him, have the right to cross-examine, and to offer evidence of his own." Also see, *Lynch v. Baxley,* at 394. In *Illinois v. Allen,* 397 U.S. 337, 342 (1969) the Court, rejecting the argument that the right to be present is absolute, held that the right of personally confronting witnesses may be lost by consent or at times even misconduct. Expanding this holding the *Lynch v. Baxley* court held that the right to be present may be knowingly and intelligently waived by persons faced with involuntary commitment or by adversary counsel acting in their behalf. This procedure protects such persons' constitutional right to be present and to assist in protecting their interests, yet it recognizes that situations exist where the

absence of such persons from commitment proceedings may serve their own best interests.

We adopt the *Lynch v. Baxley* procedure as appropriate for plaintiffs. Accordingly, we find that a child has a constitutional right to be present at all hearings concerning his proposed commitment. See, *McKiever v. Pennsylvania,* 403 U.S. 528, 543 (1971). This right may be waived by the child, however, and the unbiased tribunal may accept such a waiver upon approval by the child's counsel and upon a finding that the child understands his rights and is competent to waive them. This right may also be waived by the child's attorney, and the unbiased tribunal may accept the waiver upon a finding that the child is too ill to attend the proceedings. See, *Lynch v. Baxley,* at 394.

RIGHT TO JURY TRIAL

The Supreme Court in *McKiever v. Pennsylvania, supra,* noting that conscientious judges are able fact finders, held that while fundamental fairness requires notice, the rights to counsel, confrontation, and cross-examination, and notice of standard of proof, it does not require jury trials. We agree.

STANDARD OF PROOF

That the fact finder may commit error is a risk of any litigation. *Speiser v. Randall,* 357 U.S. 513, 525-26 (1958). The standard of proof affects this risk for it instructs the fact finder on the degree of confidence society expects him to have in the correctness of his findings. See

Mr. Justice Harlan concurring in *In re Winship,* 397 U.S. 358, 370-71 (1969). In *Winship,* Justice Harlan suggests that setting the standard of proof for a particular category of adjudication reflects an assessment of the comparative social costs of erroneous factual determinations. He views the decision to apply a preponderance standard to suits between private parties for money damages as a decision that an erroneous verdict is no more serious for one party than for the other. He finds the standard of proof beyond a reasonable doubt required in the institutionalization of a child for delinquency because the social disutility of committing an innocent child—subjecting him to a complete loss of his personal liberty—outweighs the social disutility of committing error in his favor.[21]

[21] Mr. Justice Harlan recognizes that in a judicial proceeding in which there is a dispute about the facts, all the fact finder can acquire is a belief of what probably happened. Mr. Justice White in *Goss v. Lopez,* 419 U.S. 565, 580 (1975) also recognized the possibilities of error when he noted that:

> Disciplinarians, although proceeding in utmost good faith, frequently act on the reports and advice of others; and the controlling facts and the nature of the conduct under challenge are often disputed. The risk of error is not at all trivial, and it should be guarded against if that may be done without prohibitive cost or interference with the educational process.

In discussing the possibilities of erroneous psychiatric diagnoses Rosenhan, in "On Being Sane in Insane Places," *supra,* raises several poignant questions which illustrate some of the problems in this area including:

> How many people, one wonders, are sane but not recognized as such in our psychiatric institutions? How many have been needlessly stripped of their privileges of citizenship, from the right to vote and drive to that of handling their own accounts? How many have feigned insanity in order to avoid the criminal consequences of their behavior, and, conversely,

Following this analysis, balancing the impact of an erroneous decision to commit a person with an erroneous decision to release a person, and taking into consideration the nature of the proceedings, the *Lynch v. Baxley* court held:

> Because the stigmatization and loss of liberty attendant upon forced confinement are of the most profound consequence to the individual affected, due process demands that he be subjected to such disabilities only if the necessity for his commitment is proved by evidence having the highest degree of certitude reasonably attainable in view of the nature of the matter at issue. In a civil commitment proceeding, the questions involved are the primarily subjective ones of the subject's mental condition and the likelihood that he will be dangerous in the future. Such subjective determinations cannot ordinarily be made with the same degree of certainty that might be achieved where purely objective facts and occurrences are at issue. Consequently, the trier of fact must be persuaded by clear, unequivocal, and convincing evidence that the subject of the hearing is in need of

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how many would rather stand trial than live indeterminably in a psychiatric hospital—but are wrongly thought to be mentally ill? How many have been stigmatized by well-intentioned but nevertheless erroneous diagnoses? On the last point recall again that a "type 2 error" in psychiatric diagnosis does not have the same consequences it does in medical diagnosis. A diagnosis of cancer that has been found to be in error is cause for celebration. But psychiatric diagnoses are rarely found to be in error. The label sticks, a mark of inadequacy forever.

These problems are similar to the problems discussed by Mr. Justice Harlan in *Winship* and Mr. Justice White in *Goss v. Lopez*.

> confinement under the minimum standards for commitment herein enumerated.

We agree with this holding and find that the fact finder, in a hearing on commitment of a child, must apply the standard of clear and convincing proof as opposed to the standards of beyond a reasonable doubt and preponderance of the evidence. Applying a preponderance standard creates too great a risk of erroneous commitment, wrongfully depriving a child of his interest in liberty, and interest of "transcending value,"[22] and, given the subjectivity and "relatively undeveloped state of psychiatry as a predictive science,"[23] requiring proof beyond a reasonable doubt creates too great a risk of erroneously releasing children in need of institutionalization.

RIGHTS AT THE COMMITMENT HEARING

Due process requires that before a decision to commit, an adult be given the opportunity to confront and to cross-examine witnesses against him, *Specht v. Patterson*, 386 U.S. at 610; *Lynch v. Baxley* at 394, offer evidence in his own behalf, *Specht v. Patterson* at 610, and offer testimony of witnesses, *Lynch v. Baxley* at 394, citing *White v. Texas*, 388 U.S. 14, 19 (1967).[24] While formalizing commitment procedures, these rights do not require the

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[22] *Speiser v. Randall*, 357 U.S. 513, 525 (1958).

[23] Note, Developments in the Law, Civil Commitment of the Mentally Ill, 87 Harv. L. Rev. 1190, 1302 (1974).

[24] In *Morrissey v. Brewer, supra*, the Supreme Court held that due process requires certain minimum procedures before parole can finally be revoked. These procedures include the opportunity to be heard in person and to present witnesses and documentary

state to abandon the substantive benefits it presently hopes to achieve through treatment and rehabilitation. We commend the steps the state has taken in the interest of the mental health of children in need of institutionalization but, because of the tremendous personal as well as societal loss error might cause, we find that in addition to the rights previously discussed, the rights to confront and to cross-examine witnesses against him, to offer evidence in his own behalf and to offer testimony of witnesses are required before a decision to commit a child is made.[25]

To summarize, then, we have found that before they may be institutionalized plaintiffs and others of their class are entitled to (1) a probable cause hearing within seventy-two (72) hours from the date of their initial detention; (2) a post-commitment hearing within two (2) weeks

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evidence, and the right to confront and cross-examine adverse witnesses (unless the hearing officer specifically finds good cause for not allowing confrontation). Noting that these procedures are essential in criminal trials, where a person may be subjected to the most serious deprivation, and cases where a person may lose his job in society, the Supreme Court in *Wolff, supra,* held that because of the unique problems of penal institutions the determination of whether prisoners are entitled to these rights is best left to the discretion of the officials of the prisons.

[25] In support of their position plaintiffs submitted memoranda of law outlining the substantial procedural safeguards which they contend they are being denied. They briefly mention the contention that plaintiffs should have the right to remain silent. Against this claim we must balance the practical problems plaintiffs' silence may have on psychiatric evaluation almost always needed before plaintiffs may be institutionalized. In view of these potential problems and the limited discussion of the issue in this case we think that it would be inappropriate to decide this issue at this time.

from the date of their initial detention; (3) written notice, including the date, time, and place of the hearing, and a statement of the grounds for the proposed commitment; (4) counsel at all significant stages of the commitment process and if indigent the right to appointment of free counsel; (5) be present at all hearings concerning their proposed commitment; (6) a finding by clear and convincing proof that they are in need of institutionalization; (7) the rights to confront and to cross-examine witnesses against them, to offer evidence in their own behalf, and to offer testimony of witnesses.[26] Accordingly, we declare the pertinent portions of Sections 402 and 403 unconstitutional on their face and as they apply to plaintiffs and others of their class, and we enjoin the enforcement of such portions.[27]

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[26] We neither intend nor expect that all of these procedures will be required every time an attempt to institutionalize a child is made. As we found with respect to the right of the child to be present at all hearings concerning his proposed commitment, we find that, excepting the right to notice and counsel, any or all of these rights may be waived by the child and the unbiased tribunal may accept such a waiver upon approval by the child's counsel and upon a finding that the child understands his rights and is competent to waive them. Because there may be situations where the child either does not understand his rights or is not competent to waive them, any or all of these rights may also be waived by the child's attorney and the unbiased tribunal may accept the waiver upon a finding that the waiver is appropriate.

[27] Some courts have approached claims by children of constitutional deprivation by comparing the rights afforded adults with the rights afforded children and questioning whether there is a peculiar state interest justifying any disparity between them. See *State v. Koome,* 530 P.2d 260 (Wash. 1975). Authority for such an approach can be gleaned from the Supreme Court's statement in *In re Gault,* at 29, that "So wide a gulf between the State's

The foregoing is deemed to constitute findings of fact and conclusions of law as required by F.R. Civ. P. 52 (a).

(s) John J. Gibbons,
John J. Gibbons, *C. J.*

(s) Daniel H. Huyett, 3rd,
Daniel H. Huyett, 3rd, *D. J.*

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treatment of the adult and of the child requires a bridge sturdier than mere verbiage, and reasons more persuasive than cliche can provide." Since we dispose of this case under the Due Process Clause we have no occasion to address the equal protection arguments directed at the disparate treatment of children and adults.

Plaintiffs also claim they are being denied equal protection of the law since persons above the age of eighteen (18) may voluntarily admit or commit themselves to mental institutions and persons eighteen (18) years of age or younger may not. Plaintiffs, however, failed to allege that any of the named plaintiffs ever attempted voluntarily to admit or commit themselves or even that they wish to. Accordingly, we find that plaintiffs lack standing to present this claim.

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

Civil Action No. 72-2272

Kevin Bartley, et al.

vs.

Jack B. Kremens, individually and as Hospital Director of Haverford State Hospital, et al.

ORDER

NOW, July 24, 1975, IT IS ORDERED that judgment is entered in favor of plaintiffs and against defendants. Counsel for the parties shall confer and submit an appropriate form of Order consistent with this Opinion within twenty (20) days.

(s) John J. Gibbons,
John J. Gibbons, *C. J.*

(s) Daniel H. Huyett, 3rd,
Daniel H. Huyett, 3rd, *D. J.*

Re: Kevin Bartley, et al. v. Jack B. Kremens, et al. Civil Action No. 72-2272

BRODERICK, D.J., *dissenting.*

It appears to me that the majority opinion has prescribed "an overdose" of due process which could prove fatal to the voluntary commitment of children for in-patient treatment for mental or emotional disorders. The majority opinion declares unconstitutional §§402 and 403 of the Pennsylvania Mental Health and Mental Retardation Act which provides that parents may make application for voluntary admission and commitment of their child age 18 or younger to a facility for examination, treatment and care. The due process procedure prescribed by the majority opinion for all voluntary admissions and commitments of juveniles 18 years of age and younger is as follows: (1) a probable cause hearing within 72 hours from the time of their initial detention; (2) a post- commitment hearing within 2 weeks of their initial detention; (3) written notice to the child stating the time and place of the hearing and the grounds for the proposed commitment. The notice must also be sent to the child's attorney; (4) counsel at all significant stages of the commitment process and, if indigent, the right to the appointment of free counsel; (5) the right of the child to be present at all hearings concerning his proposed commitment; (6) a finding, by "clear and convincing proof", that the child is in need of institutionalization; and (7) the right to confront and to cross-examine witnesses, and to offer evidence on his own behalf.

The Pennsylvania Mental Health and Mental Retardation Act and the regulations promulgated thereunder

provide for the voluntary admission[1] or commitment[2] of persons eighteen years of age or younger by a parent, guardian or individual standing in loco parentis to the person to be admitted. It is this voluntary admission or commitment procedure which the majority has declared unconstitutional. In effect, the majority has declared that no voluntary commitment of children by their parents can meet the constitutional requirements of the Fourteenth Amendment.

Under the Pennsylvania Act and regulations, application for voluntary admission or commitment[3] to a facility may be made by a parent, guardian or individual standing in loco parentis to the person to be admitted, if such person is eighteen years or younger.[4] In order to be admitted or committed to an institution, any person aged 18 and younger must first be referred from a recognized medical facility. Mental Health/Mental Retardation therapist or Mental Health Agency. Such referral must be accomplished by a psychiatric evaluation and a report which states with specificity the reasons that the child requires institutional care. After such referral, the director of the facility to which the parents seek to have their child ad-

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[1] 50 P.S. §4402(a)(2).

[2] 50 P.S. §4403(a)(2).

[3] The legislature chose to pass two distinct statutes, one of which deals with voluntary admissions to a facility while the other is concerned with voluntary commitments. Apparently, the main distinction in the two statutes is that under the later section dealing with voluntary commitments, the initial commitment is for a period not to exceed thirty days, with successive periods not to exceed thirty days each, so long as care or observation is necessary. The section providing for voluntary admissions contains no corresponding time limitation following admission to a facility.

[4] 50 P.S. §4402(a)(2); 50 P.S. §4403(a)(2).

mitted must then conduct an independent examination of the child in order to determine whether the child is in need of institutional care or observation. If the director's independent examination disagrees with the referring professional's opinion, the child cannot be institutionalized. In the case of a voluntary commitment under §403 of the Act, an acceptance for commitment may not exceed thirty days without a successive application for continued voluntary commitment for an additional thirty day period.[6] In the case of juveniles 13 years of age and older, within 24 hours of admission to the institution, the juvenile must be given written notification which he signs and which is to be fully explained to him and which states that he will be furnished with counsel to represent him. Should a juvenile who is 13 years of age or older object, either orally or in writing, to remaining in the institution, the director, if he feels it is necessary for the youth to remain, may continue the institutionalization for two business days, during which time notification shall be made to the applicant and the referral unit so that either party may institute a §406 proceeding, which is the statutorily required court hearing for an involuntary commitment. During that same two day period, the director must obtain counsel to represent the juvenile. The juvenile's counsel is then furnished with the evaluation of the juvenile by the referral unit, a psychiatric evaluation from the institution, and a written report of the reasons that the institution feels that institutionalization is required.[7]

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[5] 50 P.S. §4402(b); 50 P.S. §4403(b). [No corresponding text citation.]

[6] 50 P.S. §4403(b).

[7] I agree with the majority that these regulations which provide for instituting a §406 hearing do not provide for a period within which such a hearing shall be held following the objection of the child to remaining in the institution.

The effect of the Act and the regulations promulgated thereunder is that two independent medical opinions must concur in a recommendation of institutionalization before a minor can be voluntarily admitted. In the case of juveniles 13 and over, upon their objection to remaining in the institution, future institutionalization must proceed pursuant to the civil court commitment provisions of the Act (Section 406). Section 406 provides the procedure for an involuntary civil court commitment and requires the filing of a petition with the Court of Common Pleas, pursuant to which the Court issues a warrant requiring the allegedly ill person to be brought to Court for a hearing. Counsel appointed for the juvenile represents him at the hearing before the Court of Common Pleas. After the hearing, the Court may order an examination by two physicians or order commitment for a period not to exceed ten days for an examination, after which commitment may be ordered by the Court. Plaintiffs do not attack the constitutionality of the civil court commitments under §406 of the Act which follow the above outlined procedure.

I do not take the position that children have no rights. I simply feel that the procedures outlined by the Pennsylvania Legislature, when balanced against the traditional rights of parents to control the rearing of their children, afford sufficient protection to the child. The present Act does not permit a parent who seeks to admit a child under §402 or §403 to simply hand over the child to the institution. Two psychiatrists must agree, after an examination, that the child is in need of institutionalization. In the case of a voluntary commitment, a periodic review

must be performed by the director every thirty days to determine whether continued institutionalization is necessary. And in the case of a juvenile thirteen years of age and older, the juvenile is entitled to a hearing with counsel concerning his need for institutionalization following his objection. The majority in this case holds that all children are constitutionally entitled to a similar type of hearing within two weeks of their institutionalization. The only group for which the present regulations have not provided a hearing subsequent to their being received in the institution are those children 12 years of age and under. Because of this alleged defect, the majority declares §402 and §403 unconstitutional.

It is now a well settled principle that "due process 'is an elusive concept', the content of which 'varies according to specific factual contexts.'" *Hannah v. Larche,* 363 U.S. 420, 442 (1960); *Logan v. Arafeh,* 346 F. Supp. 1265, 1268 (D. Conn. 1972).

> [C]onsideration for which procedures due process may require under any given set of circumstances must begin with a determination of the precise nature of the government function involved as well as the private interest that has been affected by government action. *Cafeteria and Restaurant Workers Union, Local 473, AFL-CIO v. McElroy,* 367 U.S. 886, 895 (1961).

Due process of law does not require a hearing in every conceivable case of government impairment of private interest. *Stanley v. Illinois,* 405 U.S. 695 (1972).

An evaluation of the competing interest involved in this case leads me to the conclusion that §402 and §403 of the Act and the regulations thereunder are constitutional

on their face. Without minimizing the interest of a child 12 years and under to be free from a wrongful and unwarranted deprivation of his liberty, the traditional interest of the state in preserving the family unit and in maintaining parental control over their young children is such that the strict procedural due process requirements imposed by the majority holding as to "voluntary" commitments are not required by the Fourteenth Amendment.

The Supreme Court has repeatedly recognized and afforded great weight to the rights of parental control and custody of their children and has given due respect to the powerful role of the familial relationship in our democratic society. This substantial interest of parents undeniably warrants deference and, absent a powerful countervailing interest, warrants protection. It is plain that the interest of family integrity and the interests of parents in the care, custody and nurture of their children come to the court with a momentum deserving of respect. *Kovacs v. Cooper,* 336 U.S. 77, 95 (1949) (Frankfurter, J., concurring).

As the Supreme Court stated in *Stanley v. Illinois,* 405 U.S. 645, 651 (1972):

> The Court has frequently emphasized the importance of the family. The rights to conceive and to raise one's children have been deemed "essential," Meyer v. Nebraska, 262 U.S. 390, 399, 43 S.Ct. 625, 626, 67 L.Ed. 1042 (1923), "basic civil rights of man," Skinner v. Oklahoma, 316 U.S. 535, 541, 62 S.Ct. 1110, 1113, 86 L.Ed. 1655 (1942), and "[r]ights far more previous . . . than property rights," May v. Anderson, 345 U.S. 528, 533, 73 S.Ct. 840, 843, 97 L.Ed. 1221 (1953). "It is cardinal with

> us that the custody, care and nurture of the child reside first in the parents, whose primary function and freedom include preparation for obligations the state can neither supply nor hinder." Prince v. Massachusetts, 321 U.S. 158, 166, 64 S.Ct. 438, 442, 88 L.Ed. 645 (1944). The integrity of the family unit has found protection in the Due Process Clause of the Fourteenth Amendment, Meyer v. Nebraska, *supra,* 262 U.S. at 399, 43 S.Ct. at 626, the Equal Protection Clause of the Fourteenth Amendment, Skinner v. Oklahoma, *supra,* 316 U.S., at 541, 62 S.Ct. at 1113, and the Ninth Amendment, Griswold v. Connecticut, 381 U.S. 479, 496, 85 S.Ct. 1678, 14 L.Ed. 2d 510 (1965) (Goldberg, J., concurring).

The authorities cited above make it clear that the parents' interest in directing the upbringing of their children is cognizable and substantial. *Stanley, supra* at 652. Those who nurture the child and direct his destiny have the right coupled with the high duty, to recognize and prepare him for additional obligations. *Pierce v. Society of the Sisters of the Holy Names, etc.,* 268 U.S. 510, 535 (1925). The parents' claim to authority in their own household to direct the rearing of their children has been termed "basic to the structure of our society." *Ginsberg v. State of New York,* 390 U.S. 629, 639 (1968). In *Wisconsin v. Yoder,* 406 U.S. 205 (1972), the Supreme Court stated at 232:

> The history and culture of Western civilization reflect a strong tradition of parental concern for the nurture and upbringing of their children. This primary role of the parents in the upbringing of their children is now established beyond debate as an enduring American tradition.

As Chief Judge Bazelon of the District of Columbia Court of Appeals has stated:

> [T]he family is the most effective child-developing agent around, when it wants to be and can be. Out of the plethora of studies of day care and early intervention, one thing stands out: a child needs most a family—it is there that he finds his roots and his education. Mothers and fathers who spend time with their child are better at it than are most organized group care arrangements. David L. Bazelon, *Whose Needy Children?* University of Michigan Journal of Law Reform, vol. 8, 247.

Simply stated, it is my opinion that the present Act and the regulations thereunder which require two independent psychiatric evaluations recommending institutionalization before a parent can voluntarily have his child admitted for treatment or observation provides sufficient protection to the child against an unwarranted or unjustified institutionalization.

The record in this case demonstrates that most parents act in the best interests of their child when making the decision to voluntarily submit their child to institutional treatment. Indeed, those parents whose motives the majority opinion questions are few and far between. Children of the age of twelve and younger are at a stage of development when parents must have direct control over their care and treatment. Parents of such young children are best able to make a determination as to their child's needs, and their decision to seek institutional care and treatment for their child comes only after all other alternatives for treatment and care have been exhausted. To protect a child from being institutionalized when not in need

of such care, the State has developed a system whereby the independent judgment of two experts, trained in this difficult area, must concur with the parents' decision.[8]

As the record in this case clearly reveals, the modern trend in the treatment of the mentally and emotionally ill and the retarded is to institutionalize for the least amount of time and only when all else has failed. The majority opinion expressed concern as to the warehousing of children which might result from the voluntary commitment procedure. However, since the recent opinion of the Supreme Court in *O'Conner v. Donaldson,* 43 U.S.L.W. 4929 (1975), this fear should be dissipated by the Court's holding that a state cannot constitutionally confine a nondangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends. I find that the procedures set forth by the majority which require two hearings with counsel appointed for the child, the confrontation and cross-examination of parents and the requirement of clear and convincing proof of the need of institutional care needlessly destroys the voluntary commitment procedure without affording any significant protection for the child. The adversary nature of the procedure which the majority requires will significantly increase the trauma which accompanies the institutionalization of sick children and will further serve to stigmatize the recipient of the court endorsed commitment. In my opinion, it retards society's progress of recent years in encouraging parents to seek treatment and care of a child in need of hospitalization for a mental or emotional disorder. It will likewise retard society's progress toward removing the stigma still associated by some with psychiatric care. The majority opinion discusses "the stigma associated with civil commitment", yet sets up a system which makes civil commitment necessary. For years now, responsible leaders have been counseling the public that treatment for mental and emotional disorders should be as readily available and as readily acceptable as hospitalization for a tonsillectomy or appendectomy. It certainly will not encourage parents to seek hospitalization for a mentally or emotionally disturbed child when the parent learns that counsel will be appointed for the child and that there will be an adversary hearing at which parents will be subjected to cross-examination as to their motives for seeking hospitalization.

[8] I am aware that courts in Nebraska and Tennessee have declared unconstitutional statutes which permit the voluntary institutionalization of children. *Horacek, etc. v. Exon, et al.*, Civil Action No. 74-L-299 (D.C. Neb. 1974). *Saville v. Treadway,* Civil Action No. 6969 (M.D. Tenn. 1974). However, it is not apparent from reading the opinions in those cases whether both Nebraska and Tennessee provide a protective procedure similar to those provided for under the Pennsylvania statute and regulations.

COURT'S PROPOSED ORDER—SEPTEMBER 16, 1975

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

Civil Action No. 72-2272

Kevin Bartley, et al.

vs.

Jack B. Kremens, Individually and as Hospital Director of Haverford State Hospital, et al.

ORDER

Before Honorable John J. Gibbons, Circuit Judge, and Honorable Daniel H. Huyett, 3rd, and Honorable Raymond J. Broderick, District Judges

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HUYETT, J. September , 1975

On July 24, 1975, we filed our opinion and order in this action granting judgment in favor of plaintiffs and against defendants. Pursuant to Fed. R. Civ. P. 58 and 65 (d), we now enter the following Order to provide and implement the declaratory and injunctive relief to which we held plaintiffs entitled in our opinion.

CLASS ACTION

1. This action is properly maintained as a class action under Fed. R. Civ. P. 23 (b) (2). The class represented by the named plaintiffs includes all children eighteen years of age or younger who have been, are, or may be admitted or committed to mental health facilities in Pennsylvania under the Pennsylvania Mental Health and Mental Retardation Act of 1966. 50 P.S. §§4402 and 4403 (§§402 and 403).

DECLARATORY JUDGMENT

2. Section 402 (a) (2), section 402 (c), except for the language "any person voluntarily admitted shall be free to withdraw at any time," and section 403 (a) (2) of the Pennsylvania Mental Health and Mental Retardation Act (Act) are declared to be unconstitutional on their face and as applied under the due process clause of the Fourteenth Amendment to the United States Constitution.

Notice

3. These sections of the Act are declared invalid in that they fail to require that children eighteen years of age or younger receive prior written notice of the date, time, and place of both the probable cause and full commitment hearings and a statement of the grounds for the proposed commitment; the child's attorney must be in receipt of notice at least forty-eight (48) hours prior to the initial hearing. Until the legislature establishes some other procedure consonant with our opinion and order, it is declared that this notice must be sent not only to the child but also the Clerk of the Court with jurisdiction to be forwarded to the child's attorney.

Counsel

4. These sections of the Act are declared invalid in that they fail to require during all significant stages of the commitment process counsel for children eighteen years of age or younger and, if the child is indigent, appointment of free counsel.

Presence of Child

5. These sections of the Act are declared invalid in that they fail to afford to children eighteen years of age or younger subject to commitment hearings the rights to presence with counsel, an opportunity to be heard, confrontation and cross-examination of adverse witnesses, and the opportunity to offer the testimony of witnesses and other evidence on their own behalf.

Standard of Proof

6. These sections of the Act are declared invalid in that they fail to require that the fact finder in a full hearing on the commitment of a child eighteen years of age or younger find by clear and convincing proof that the child is in need of institutionalization.

Probable Cause Hearing

7. These sections of the Act are declared invalid in that they permit detention of children eighteen years of age or younger for more than seventy-two (72) hours without a hearing to test whether there is probable cause to believe institutionalization is necessary. These sections of the Act are further declared invalid in that they fail to provide at a probable cause hearing the rights delineated in paragraphs 3 through 5 above.

Full Commitment Hearing

8. These sections of the Act are declared invalid in that in the event the initial hearing determines the existence of probable cause, they fail to afford to children eighteen years of age or younger a full hearing on the need for commitment within two weeks from the date of initial detention. These sections of the Act are further declared invalid in that they fail to provide at a full commitment hearing the rights delineated in paragraphs 3 through 6 above.

Regulations

9. The regulations promulgated by defendant Wohlgemuth to supplement these sections of the Act, published at 3 Pa. Bull. 1840, are declared invalid and in violation of the due process clause of the Fourteenth Amendment to the United States Constitution in that they fail to require for all children eighteen years of age or younger the rights delineated in paragraphs 3 through 8 above.

Admissions and Commitments of Plaintiffs

10. It is declared that all children eighteen years of age or younger admitted or committed to mental health facilities in Pennsylvania under these sections of the Act are unconstitutionally held and detained.

Use of State Courts

11. Until the legislature establishes in accord with our opinion and orders an alternate neutral tribunal to conduct the probable cause and full commitment hearings, it is declared that the present facilities of the Commonwealth court system be used for these hearings.

Application for Treatment of Juveniles

12. It is declared that a parent, guardian, or person standing in loco parentis may initiate the temporary detention of a child eighteen years of age or younger in a mental health facility if the procedures and requirements of our opinion and order are fully complied with.

Requirements for Commitment

13. It is declared that all children eighteen years of age or younger who have been, are, or may be subject to admission or commission to a mental health facility in Pennsylvania are entitled to:

Notice

A. Prior written notice of the date, time, and place of both the probable cause and full commitment hearings and a statement of the grounds for the proposed commitment; the child's attorney must be in receipt of notice at least forty-eight (48) hours prior to the initial hearing. Until the legislature establishes some other procedure consonant with our opinion and order, this notice must be sent not only to the child but also to the Clerk of the Court with jurisdiction to be forwarded to the child's attorney.

Counsel

B. Counsel during all significant stages of the commitment process and, if the child is indigent, appointment of free counsel.

Presence of Child and Other Hearing Rights

C. Presence of the child at all commitment hearings, an opportunity to be heard, confrontation and cross-examination of adverse witnesses, and an opportunity to offer testimony of witnesses and other evidence on the child's behalf.

Standard of Proof

D. A finding by clear and convincing proof at the full commitment hearing that the child is in need of institutionalization.

Probable Cause Hearing

E. A hearing within seventy-two (72) hours from the date of the initial detention to test whether or not there is probable cause to believe that institutionalization is necessary.

Full Commitment Hearing

F. A full commitment hearing within two (2) weeks from the date of the initial detention.

Waiver

14. Excepting the rights to notice and counsel, any or all of the rights delineated in paragraph 13 may be waived by the child, and the neutral tribunal may accept such a waiver upon approval by the child's counsel and upon a finding that the child understands his rights and is competent to waive them. Because there may be situations where the child either does not understand his rights or is not competent to waive them, any or all of these rights, excepting notice and counsel, may also be waived by the child's attorney, and the neutral tribunal may accept the waiver upon a finding that the waiver is appropriate.

INJUNCTIVE RELIEF

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15. It is ordered that the operation of section 402(a)(2), section 402(c), except for the language "any person voluntarily admitted shall be free to withdraw at any time," and section 403(a)(2) of the Pennsylvania Mental Health and Mental Retardation Act (Act) is enjoined in that these sections of the Act are unconstitutional on their face and as applied under the due process

clause of the Fourteenth Amendment to the United States Constitution. It is further ordered that the defendants and their officers, agents, servants, employees, successors, and those persons in active concert or participation with them are enjoined:

Procedures

A. To refrain from accepting or continuing the admission or commitment of any child eighteen years of age or younger under the Act to any mental health facility unless the child is or has been provided:

(1) Prior written notice of the date, time and place of both the probable cause and full commitment hearings and a statement of the grounds for the proposed commitment; the child's attorney must be in receipt of notice at least forty-eight (48) hours prior to the initial hearing. Until the legislature established some other procedure consonant with our opinion and order, this notice must be sent not only to the child but also to the Clerk of the Court with jurisdiction to be forwarded to the child's attorney.

(2) Counsel during all significant stages of the commitment process and, if the child is indigent, appointment of free counsel.

(3) Presence of the child at all commitment hearings, an opportunity to be heard, confrontation and cross-examination of adverse witnesses, and an opportunity to offer testimony of witnesses and other evidence on the child's behalf.

(4) A finding by clear and convincing proof at the full commitment hearing that the child is in need of institutionalization.

(5) A hearing within seventy-two (72) hours from the date of the initial detention to test whether or not there is probable cause to believe that institutionalization is necessary.

(6) A full commitment hearing within two (2) weeks from the date of the initial detention.

Excepting the rights to notice and counsel, any or all of the rights delineated in paragraph 15(A) may be waived by the child, and the neutral tribunal may accept such a waiver upon approval by the child's counsel and upon a finding that the child understands his rights and is competent to waive them. Because there may be situations where the child either does not understand his rights or is not competent to waive them, any or all of these rights, excepting notice and counsel, may also be waived by the child's attorney, and the neutral tribunal may accept the waiver upon a finding that the waiver is appropriate.

Regulations

B. To promulgate and issue regulations and to publish them, within thirty (30) days as immediately effective, requiring that all mental health facilities in Pennsylvania (*see* 50 P.S. §4102 for the definition of "facility") adhere to the opinion and order in this action.

Notice of Order

C. To give notice forthwith to all state school and mental hospital directors and their delegates and all directors of all other mental health facilities in Pennsylvania of the opinion and order in this action. Further, to give notice forthwith to all judges of the Courts of Common Pleas in Pennsylvania of the opinion and order in this action.

Access for Attorneys

D. To provide to attorneys access to the grounds and facilities of all mental hospitals and institutions, to their individual clients, and to the institutional and hospital records pertaining to their clients' commitments.

Procedures for Children Already Admitted or Committed

E. To initiate procedures, commencing immediately, to assure that all children eighteen years of age or younger already admitted or committed pursuant to §§402 and 403 are either discharged or released or recommitted according to the procedures required by our opinion and order. Such discharge, release, or recommitment shall begin immediately and shall be concluded within one hundred and twenty (120) days of the date of this order. Notation shall be made upon the medical records of such children that their discharge, release, or recommitment was effected pursuant to the opinion and order in this action.

Reports on Implementation

F. To report to this Court within sixty (60) days and again within one hundred and fifty (150) days on the steps taken and progress made in the implementation of our opinion and order. The one hundred and fifty-day report shall describe, for each mental health facility, the number of children eighteen years of age or younger released, discharged, or recommitted.

_____

C. J.

_____

D. J.

_____

D. J.

DEFENDANTS' EXCEPTIONS TO COURT'S PROPOSED ORDER—OCTOBER 17, 1975

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

[Title omitted in printing]

EXCEPTIONS TO PROPOSED ORDER

The Defendants by their counsel, Barry A. Roth, Assistant Attorney General, hereby take exceptions pursuant to Federal Rule of Civil Procedure 46 to the Proposed Order which was issued in the above-captioned matter on or about the 16th day of September, 1975, and make the following representations:

1. The Opinion in this matter was issued on July 24, 1975. (Exhibit A) (22a).

2. A dissenting opinion in this matter was issued on August 7, 1975. (Exhibit B) (52a).

3. Pursuant to This Honorable Court's instruction, Defendants submitted a proposed form of final order (attached hereto as Exhibit C and made a part hereof) (72a) together with an accompanying letter dated August 21, 1975 (attached hereto as Exhibit D and made a part hereof).

4. Pursuant to This Honorable Court's instruction, Plaintiffs submitted a proposed form of final order (at-

tached hereto as Exhibit E and made a part hereof) (62a) together with an accompanying letter dated August 5, 1975 (attached hereto as Exhibit F and made a part hereof), and in addition, a response letter to Defendants' August 21, 1975 letter (see Exhibit D) (attached hereto as Exhibit G and made a part hereof).

5. This Honorable Court submitted a proposed order to all counsel of record for comment (attached hereto as Exhibit H and made a part hereof) (77a).

6. Defendants hereby propound the following exceptions to This Honorable Court's proposed order (see Exhibit H):

A. Paragraph 3 requires that a child's attorney must receive notice of the probable cause hearing or post-commitment hearing 48 hours prior to that hearing; however, there is no method by which the Commonwealth, and in particular the Pennsylvania Department of Public Welfare can even attempt to assure that an attorney who is not yet appointed or selected will be in receipt of that notice.

B. Paragraph 3 requires that notice be sent to the child and the clerk of courts for forwarding to the child's attorney and that a probable cause hearing be held within 72 hours from the date of the child's detention. However, the proposed order does not establish if the child may be detained in the event the child's attorney is not appointed within the 72-hour period. The Opinion, however, states, "in no event shall detention of the child in the absence of a probable cause hearing exceed seventy-two (72) hours from the date of the initial detention." (Exhibit A, p. 16).

C. Paragraph 3 requires notice to be sent by, we assume, the Department of Public Welfare to the Court who, in turn, sends it to counsel for the child, and this must be accomplished within 24 hours of the child's admission. The Department cannot assure that an unknown attorney will receive notice of the child's admission 48 hours prior to the probable cause hearing and 24 hours after the juvenile was admitted; however, address has not been made, if the conditions above were met, if an attorney can adequately prepare his case within 24 hours before the hearing.

D. Paragraph 3 requires notice of the child's admission/commitment be sent to the clerk of the court with jurisdiction; however, is jurisdiction to be determined by the location of the institution or by the county from which the child came?

E. Paragraph 3 fails to provide notice to the parent, guardian, or juvenile's applicant.

F. No provision has been made for a continuance, either by the juvenile, parent, hospital, or master.

G. Paragraphs 5 through 8 and 13 require legal representation for the juvenile. The Commonwealth does not object to representation of children by attorneys; however, in light of *Edleman v. Jordan*, this proposed order compels the State to expend funds from its treasury to pay for counsel for indigent juveniles without legislative authority and appropriations. Our order suggests that the public defender or an alternative organization like community legal services which have statutory or clear grant respon-

sibility to accept as clients all who fall within economic guidelines, be referred the cases of indigent juveniles. No standards of indigency have been set forth and a serious question arises if the parent must pay for counsel to his child. Otherwise, until the Legislature provides an alternative source of counsel for indigent juveniles involved in these types of proceedings, it would be unlawful for This Court to order the Commonwealth to pay for said attorneys.

H. Paragraph 11 designates the Commonwealth Court system as the judicial system for the probable cause and full commitment hearings. This Court is thus creating a cause of action in a separate judicial system without a present legislative or common law foundation. As of October 2, 1975, in an amended petition of writ of habeas corpus, petitioner seeks to have declared Section 408 of the Mental Health and Mental Retardation Act of 1966 unconstitutional because there is a violation of equal protection according to the procedural requirements set forth in *Bartley. In re Bingaman,* Common Pleas Court of Snyder County, No. 496, 1975. It is unclear and a matter of substantial controversy whether a Federal District Court has the authority under the Constitution of the United States or any act of Congress to exercise such direction and control over the Commonwealth's judicial branch of government and its judicial officers.

I. In paragraph 11 This Honorable Court declares that the present facilities of the Commonwealth Court system be used for these hearings and directs that the Legislature order an alternate neutral tribunal

to conduct probable cause and full commitment hearings (Exhibit H, p. 4). However, This Honorable Court fails to realize that the Legislature may provide for an equally constitutional method other than by using the Commonwealth Court system, such as the use of a masters (which is prevalent in the 406 commitment process).

J. Paragraphs 13 and 15 provide the child with an opportunity to offer testimony of witnesses; however, who bears the expense for professional testimony such as psychiatric or psychological testimony? This requirement compels the State to expend funds from its treasury to pay for services which are in direct violation of *Edleman v. Jordan.*

K. Paragraph 15(E) requires the discharge, release, or recommitment of institutionalized juveniles to be accomplished within 120 days from the date of this order. This Honorable Court is without jurisdiction and without authority to order the release or conditional release of juveniles already in custody at State institutions within the context of this civil rights action. The exclusive method by which such relief may be obtained is habeas corpus. Further, pursuant to 28 U.S.C. §2254(b), exhaustion of state remedies is a prerequisite to federal jurisdiction in habeas corpus proceedings. The presentation of a civil rights claim requires no such exhaustion; however, it is not permissible to pursue a habeas corpus remedy through a civil rights action and thus avoid the necessity of referring to the state judicial system for habeas corpus. *Preiser v. Rodriguez,* 411 U.S. 475 (1973).

L. Paragraph 15(E) requires the discharge, release, or recommitment of all juveniles within 120 days from the date of this order. As previously stated, This Court is without jurisdiction and authority to order the release or conditional release of juveniles already in custody at state institutions within the context of this civil rights action. The exclusive method by which such relief may be obtained is habeas corpus. *Preiser v. Rodriguez*, 411 U.S. 475 (1973). The Department cannot programmatically effectuate the Court's requirement to recommit all institutionalized juveniles within 120 days and will have no choice but to discharge this group which approximates 7,000 juveniles to their parents and guardians. No aftercare is provided. The effect of this requirement will cause great harm to this class, the majority of which are severely retarded. Furthermore, discharge in several instances may not occur because parents may refuse to have their child returned to them and appropriate proceedings before the local court will be needed to effectuate appointment of a guardian ad litem for the child.

M. Paragraph 15(E) requires the discharge, release, or recommitment of all juveniles within 120 days from the date of this order. As previously stated, This Court is without jurisdiction and authority to order the release or conditional release of juveniles already in custody at state institutions within the context of this civil rights action. The exclusive method by which such relief may be obtained is habeas corpus. *Preiser v. Rodriguez*, 411 U.S. 475 (1973). It is recommended that notation of each child's condition be made upon the child's medical

record and forwarded to a guardian ad litem to be appointed by This Honorable Court for the express purpose of seeking a writ of habeas corpus action for each child whom the guardian ad litem feels is inappropriately institutionalized. More than 7,000 juveniles are currently located in State mental hospitals, State schools and hospitals, private licensed facilities, etc., and the majority of these children are severely retarded thereby making them incapable of exercising any judgment regarding their commitment.

N. Paragraph 15(F) requires time limits. It is impossible to implement some or all of the requirements of This Court's proposed order within the time indicated for reporting on implementation. Legislative authority is requisite to most, if not all of the proposed procedures required by paragraph 15 of the proposed order. Since the Legislature convened only for a brief session in September and October, and does not reconvene until after the general election in November, at least 180 days from the issuance of the final order is necessary for the Legislature to authorize implementation of appropriate procedures. The Department of Public Welfare has discussed and sent to Senator Louis Coppersmith copies of the Court's Opinion and our exceptions thereto for introducing legislation.

O. An affidavit by Stanley Meyers, Deputy Secretary for Mental Retardation, setting forth the difficulties of implementing This Court's proposed order is attached as Exhibit I.

P. An affidavit by Dr. James Harris, Deputy Secretary for Mental Health and Medical Services

and Commissioner of Mental Health, sets forth the difficulties of implementing This Court's proposed order and is attached as Exhibit J.

Q. The proposed order erroneously makes no provision allowing for the continuation of the "respite care" program or the intensive training program within the Mental Health/Mental Retardation program of the Commonwealth.

R. The Pennsylvania Court Administrator has informed us that he will be writing to the Court and excepting to the proposed order. He is a necessary party to these proceedings and the Commonwealth subscribes to his objections insofar as they effect the Commonwealth.

S. Paragraph 15(F) requires us to submit reports within 60 days and within 150 days a report of our progress and implementation of the proposed order. It is impossible for the reasons mentioned heretofore to accomplish the structure set forth by This Honorable Court within the time limits. Accordingly, we submit that progress reports be afforded to This Honorable Court every three months until accomplishment of the order occurs, and at that time a full report setting forth the number of children 18 years of age or younger who are committed pursuant to Sections 402 and 403 of the Act.

7. General Exceptions

A. This Court is without jurisdiction and without authority to order the release or conditional release of juveniles already in custody at State institutions within the context of this civil rights action.

The *exclusive method* by which such relief may be obtained is habeas corpus. Further, pursuant to 28 U.S.C. 2254(b), exhaustion of state remedies is a prerequisite to federal jurisdiction in habeas corpus proceedings. The presentation of a civil rights claim requires no such exhaustion; however, it is not permissible to pursue a habeas corpus remedy through a civil rights action and thus avoid the necessity of referring to the state judicial system for habeas corpus. *Preiser v. Rodriguez*, 411 U.S. 475 (1973). Additionally, Plaintiffs never sought release of juveniles in State mental health facilities.

B. This Court's proposed order compels the State to expend funds from its treasury to pay for counsel for indigent juveniles without legislative authority and appropriations. This action is in direct violation of *Edleman v. Jordan*, 415 U.S. 651 (1974).

C. It is unclear and a matter of substantial controversy whether a Federal District Court has the authority under the Constitution of the United States or any act of Congress to exercise such discretion and control over the Commonwealth's judicial branch of government and its judicial officers. Thus, This Court, in essence, has created a cause of action in a separate judicial system without a present legislative or common law foundation. To wit, an amended petition of writ of habeas corpus has been filed in the Common Pleas Court of Snyder County, No. 496, 1975 term, in which petitioner seeks to have declared unconstitutional Section 408 of the Mental Health and Mental Retardation Act of 1966 because there is a violation of equal protection according to the pro-

cedural requirements set forth in *Bartley. In re Bingaman.*

D. While there may have been evils within existing State laws, it is case legend that the protection afforded is a matter for legislative judgment. Consequently, it would be improper to have a permanent order substitute for legislative judgment *Gunn v. University Committee To End the War in Vietnam,* 399 U.S. 383 (1970); *Robinson v. Cahill,* 62 N.J. 473, 520, 521, 303 A.2d 273, 298 (1973); *Federal Power Commission v. National Gas Pipeline Company,* 315 U.S. 575, 599, 601 (1942); *Marbury v. Madison,* 2 L.Ed. 60.

Respectfully submitted,

(s) Barry A. Roth
Barry A. Roth
Assistant Attorney General

Paul J. Carey, Jr.
General Counsel

Robert P. Kane
Attorney General

323 Health and Welfare Building
Harrisburg, Pennsylvania 17120
(717) 787-6398
October 17, 1975

FINAL ORDER—NOVEMBER 17, 1975

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

Civil Action No. 72-2272

Kevin Bartley, et al.

vs.

Jack B. Kremens, Individually and as Hospital Director of Haverford State Hospital, et al.

ORDER

Before Honorable John J. Gibbons, Circuit Judge, and Honorable Daniel H. Huyett, 3rd, and Honorable Raymond J. Broderick, District Judges

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HUYETT, J. November 17, 1975:

On July 24, 1975, we filed our opinion and order in this action granting judgment in favor of plaintiffs and against defendants. Pursuant to Fed. R. Civ. P. 58 and 65(d), we now enter the following Order to provide and implement the declaratory and injunctive relief to which we held plaintiffs entitled in our opinion.

CLASS ACTION

1. This action is properly maintained as a class action under Fed. R. Civ. P. 23(b)(2). The class represented by the named plaintiffs includes all children eighteen years of age or younger who have been, are, or may be admitted or committed to mental health or mental retardation facilities in Pennsylvania under the Pennsylvania Mental Health and Mental Retardation Act of 1966. 50 P.S. §§4402 and 4403 (§§402 and 403).

DECLARATORY JUDGMENT

2. Section 402(a)(2), section 402(c), except for the language "any person voluntarily admitted shall be free to withdraw at any time," and section 403(a)(2) of the Pennsylvania Mental Health and Mental Retardation Act (Act) are declared to be unconstitutional on their face and as applied under the due process clause of the Fourteenth Amendment to the United States Constitution.

Notice

3. These sections of the Act are declared invalid in that they fail to require that children eighteen years of age or younger receive prior written notice of the date, time, and place of both the probable cause and full commitment hearings and a statement of the grounds for the proposed commitment; the child's attorney must be in receipt of notice at least forty-eight (48) hours prior to the initial hearing. Until the legislature establishes some other procedure consonant with our opinion and order, it is declared that this notice must be sent not only to the child but also the Clerk of the Court with jurisdiction to be forwarded to the child's attorney.

Counsel

4. These sections of the Act are declared invalid in that they fail to require during all significant stages of the commitment process counsel for children eighteen years of age or younger and, if the child is indigent, appointment of free counsel.

Presence of Child

5. These sections of the Act are declared invalid in that they fail to afford to children eighteen years of age or younger subject to commitment hearings the rights to presence with counsel, an opportunity to be heard, confrontation and cross-examination of adverse witnesses, and the opportunity to offer the testimony of witnesses and other evidence on their own behalf.

Standard of Proof

6. These sections of the Act are declared invalid in that they fail to require that the fact finder in a full hearing on the commitment of a child eighteen years of age or younger find by clear and convincing proof that the child is in need of institutionalization.

Probable Cause Hearing

7. These sections of the Act are declared invalid in that they permit detention of children eighteen years of age or younger for more than seventy-two (72) hours without a hearing to test whether there is probable cause to believe institutionalization is necessary. These sections of the Act are further declared invalid in that they fail to provide at a probable cause hearing the rights delineated in paragraphs 3 through 5 above.

Full Commitment Hearing

8. These sections of the Act are declared invalid in that in the event the initial hearing determines the exis-

tence of probable cause, they fail to afford to children eighteen years of age or younger a full hearing on the need for commitment within two weeks from the date of initial detention. These sections of the Act are further declared invalid in that they fail to provide at a full commitment hearing the rights delineated in paragraphs 3 through 6 above.

Regulations

9. The regulations promulgated by defendant Wohlgemuth to supplement these sections of the Act, published at 3 Pa. Bull. 1840, are declared invalid and in violation of the due process clause of the Fourteenth Amendment to the United States Constitution in that they fail to require for all children eighteen years of age or younger the rights delineated in paragraphs 3 through 8 above.

Admissions and Commitments of Plaintiffs

10. It is declared that all children eighteen years of age or younger admitted or committed to mental health or mental retardation facilities in Pennsylvania under these sections of the Act are unconstitutionally held and detained.

Use of State Courts

11. Until the legislature establishes in accord with our opinion and order an alternate neutral tribunal to conduct the probable cause and full commitment hearings, it is declared that the present facilities of the Commonwealth court system be used for these hearings.

Application for Treatment of Juveniles

12. It is declared that a parent, guardian, or person standing in loco parentis may initiate the temporary detention of a child eighteen years of age or younger in a mental health or mental retardation facility if the procedures and requirements of our opinion and order are fully complied with.

Requirements for Commitment

13. It is declared that all children eighteen years of age or younger who have been, are, or may be subject to admission or commission to a mental health or mental retardation facility in Pennsylvania are entitled to:

Notice

A. Prior written notice of the date, time, and place of both the probable cause and full commitment hearings and a statement of the grounds for the proposed commitment; the child's attorney must be in receipt of notice at least forty-eight (48) hours prior to the initial hearing. Until the legislature establishes some other procedure consonant with our opinion and order, this notice must be sent not only to the child but also to the Clerk of the Court with jurisdiction to be forwarded to the child's attorney.

Counsel

B. Counsel during all significant stages of the commitment process and, if the child is indigent, appointment of free counsel.

Presence of Child and Other Hearing Rights

C. Presence of the child at all commitment hearings, an opportunity to be heard, confrontation and cross-examination of adverse witnesses, and an opportunity to offer testimony of witnesses and other evidence on the child's behalf.

Standard of Proof

D. A finding by clear and convincing proof at the full commitment hearing that the child is in need of institutionalization.

Probable Cause Hearing

E. A hearing within seventy-two (72) hours from the date of the initial detention to test whether or not there is probable cause to believe that institutionalization is necessary.

Full Commitment Hearing

F. A full commitment hearing within two (2) weeks from the date of the initial detention.

Waiver

14. Excepting the rights to notice and counsel, any or all of the rights delineated in paragraph 13 may be waived by the child, and the neutral tribunal may accept such a waiver upon approval by the child's counsel and upon a finding that the child understands his rights and is competent to waive them. Because there may be situations where the child either does not understand his rights or is not competent to waive them, any or all of these rights, excepting notice and counsel, may also be waived by the child's attorney, and the neutral tribunal may accept the waiver upon a finding that the waiver is appropriate.

INJUNCTIVE RELIEF

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15. It is ordered that the operation of section 402 (a) (2), section 402 (c), except for the language "any

person voluntarily admitted shall be free to withdraw at any time," and section 403 (a) (2) of the Pennsylvania Mental Health and Mental Retardation Act (Act) is enjoined in that these sections of the Act are unconstitutional on their face and as applied under the due process clause of the Fourteenth Amendment to the United States Constitution. It is further ordered that the defendants and their officers, agents, servants, employees, successors, and those persons in active concert or participation with them are enjoined:

Procedures

A. To refrain from accepting or continuing the admission or commitment of any child eighteen years of age or younger under the Act to any mental health or mental retardation facility unless the child is or has been provided:

(1) Prior written notice of the date, time, and place of both the probable cause and full commitment hearings and a statement of the grounds for the proposed commitment; the child's attorney must be in receipt of notice at least forty-eight (48) hours prior to the initial hearing. Until the legislature establishes some other procedure consonant with our opinion and order, this notice must be sent not only to the child but also to the Clerk of the Court with jurisdiction to be forwarded to the child's attorney.

(2) Counsel during all significant stages of the commitment process and, if the child is indigent, appointment of free counsel.

(3) Presence of the child at all commitment hearings, an opportunity to be heard, confrontation

and cross-examination of adverse witnesses, and an opportunity to offer testimony of witnesses and other evidence on the child's behalf.

(4) A finding by clear and convincing proof at the full commitment hearing that the child is in need of institutionalization.

(5) A hearing within seventy-two (72) hours from the date of the initial detention to test whether or not there is probable cause to believe that institutionalization is necessary.

(6) A full commitment hearing within two (2) weeks from the date of the initial detention.

Excepting the rights to notice and counsel, any or all of the rights delineated in paragraph 15(A) may be waived by the child, and the neutral tribunal may accept such a waiver upon approval by the child's counsel and upon a finding that the child understands his rights and is competent to waive them. Because there may be situations where the child either does not understand his rights or is not competent to waive them, any or all of these rights, excepting notice and counsel, may also be waived by the child's attorney, and the neutral tribunal may accept the waiver upon a finding that the waiver is appropriate.

Regulations

B. To promulgate and issue regulations and to publish them, within thirty (30) days as immediately effective, requiring that all mental health and mental retardation facilities in Pennsylvania (*see* 50 P.S. §4102 for the definition of "facility") adhere to the opinion and order in this action.

Notice of Order

C. To give notice forthwith to all state school and mental hospital directors and their delegates and all directors of all other mental health and mental retardation facilities in Pennsylvania of the opinion and order in this action. Further, to give notice forthwith to all judges of the Courts of Common Pleas in Pennsylvania of the opinion and order in this action.

Access for Attorneys

D. To provide to attorneys access to the grounds and facilities of all mental hospitals and institutions, to their individual clients, and to the institutional and hospital records pertaining to their clients' commitments.

Procedures for Children Already Admitted or Committed

E. To initiate procedures, commencing immediately, to assure that all children eighteen years of age or younger already admitted or committed pursuant to §§402 and 403 are either discharged or released or recommitted according to the procedures required by our opinion and order. Such discharge, release, or recommitment shall begin immediately and shall be concluded within one hundred and twenty (120) days of the date of this order, unless an extention is granted by this Court for good cause shown. Notation shall be made upon the medical records of such children that their discharge, release, or recommitment was effected pursuant to the opinion and order in this action. In addition, any person admitted or committed pursuant to §§402 or 403 at a time when he or she was eighteen years of age or younger but who has reached his or her nineteenth birthday shall be brought before a Commonwealth court or alternate neutral tribunal and informed of his or her options under §§402 and 403 for

voluntary withdrawal. Should such person choose to withdraw voluntarily, he or she shall be released immediately unless proper procedures are initiated pursuant to the appropriate Pennsylvania statutes governing the involuntary commitment of adults.

Reports on Implementation

F. To report to this Court within sixty (60) days and again within one hundred and fifty (150) days on the steps taken and progress made in the implementation of our opinion and order. The one hundred and fifty-day report shall describe, for each mental health or mental retardation facility, the number of children eighteen years of age or younger released, discharged or recommitted and the number of persons who have reached their nineteenth birthday but who were eighteen years of age or younger at the time they were admitted or committed pursuant to §402 or §403 who have been released, voluntarily admitted or committed, or involuntarily committed.

(s) John J. Gibbons
C. J.

(s) Daniel A. Huyett 3rd
D. J.

(s) R. J. Broderick
D. J.

NOTICE OF APPEAL

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

Civil Action No. 72-2272

Kevin Bartley; Steve Gentile; Lesile Levine; Vicki Mathews; Mark Weand; minors, through their next friend, individually and on behalf of all others similarly situated,
Plaintiffs

v.

Jack B. Kremens, individually and as Hospital Director of Haverford State Hospital; Helene Wohlgemuth, individually and as Secretary of Public Welfare of the Commonwealth of Pennsylvania; William B. Beach, Jr., individually and as Deputy Secretary for Mental Health and Mental Retardation of the Department of Public Welfare of the Commonwealth of Pennsylvania,
Defendants

NOTICE OF APPEAL TO THE SUPREME COURT OF THE UNITED STATES

Notice is hereby given that Jack B. Kremens, et al., the Defendants above-named, hereby appeal to the Supreme Court of the United States from the final order granting a permanent injunction in favor of Plaintiffs and

against Defendants, entered in this action on November 17, 1975.

This appeal is taken pursuant to 28 U.S.C. §1253.

(s) Barry A. Roth
Barry A. Roth
Assistant Attorney General
Counsel for Defendants

[Caption Omitted]

AFFIDAVIT OF SERVICE

Barry A. Roth certifies that he, by certified mail, return receipt requested, served:

David Ferleger, Esq.
1427 Walnut Street
Philadelphia, Pa. 19102

John Gabroy, Esq.
1710 Spruce Street
Philadelphia, Pa. 19103

Thomas B. Harvey, Jr.
American Civil Liberties Foundation
260 South 15th Street
Philadelphia, Pa. 19102

Jay Stanley Pottinger
Assistant U. S. Attorney General
Department of Justice
Washington, D.C. 20530

Robert C. Burgdorf
National Association for Retarded Citizens
1235 North Eddy Street
South Bend, Indiana 46617

Peter Sandman
Youth Law Center of California
795 Turk Street
San Francisco, California 94102

by sending them a copy of the Notice of Appeal at the above address.

(s) Barry A. Roth
Barry A. Roth
Assistant Attorney General

Dated:

Sworn to and subscribed before me on this 24th day of November, 1975.

[Illegible]
Notary Public

IN THE SUPREME COURT OF THE UNITED STATES

October Term, 1975
No.

[Title omitted in printing.]

To Mr. Justice Brennan, Circuit Justice:

APPLICATION FOR A STAY[1]

Appellants, by this application, *inter alia* seek to protect the integrity of the Commonwealth of Pennsylvania's legislative, judicial and executive branches of government as well as the Commonwealth's general fund in keeping with this court's holding in *Edelman v. Jordan*, 415 U.S. 651 (1974). Moreover, the appellants seek to preserve the delicate balance between competing jurisdictions in the traditional area of habeas corpus relief as set forth by this Court in *Preiser v. Rodriguez*, 411 U.S. 475 (1973).

The order of the lower court enjoining the continued use of Pennsylvania's statutes which prescribe the method by which juveniles may be voluntarily committed to mental health facilities in Pennsylvania[2] (See pp. 1, 2 of Exhibit

[1] The Defendants' Motion for a Stay was denied by the lower Court on December 2, 1975 (Motion and Order attached hereto as Exhibit A).

[2] Act of October 20, 1966, special sess. No. 3, P.L. 96, art. IV, §§402, 403, 50 P.S. §§4402, 4403 (1966).

(D)) must be stayed pending review by this Court in order to prevent an irreversible injury to the aforementioned interests of the Commonwealth. In support of this application, the appellants assert:

PROCEEDINGS BELOW

1. This class action was brought under the Civil Rights Act, 42 U.S.C. §1983 and sought both declaratory and injunctive relief against the continued operation of sections 402 and 403 of Pennsylvania's Mental Health and Mental Retardation Act. A three judge court was convened and a majority thereof issued the attached opinion on July 24, 1975 (See Exhibits B and C).[3] And finally, over defendants' strong objections, on November 17, 1975, the final order was issued in this case (Exhibit D).

2. The Defendants took formal exceptions to the lower Courts' order (Exhibit B and F).

REASONS FOR GRANTING THE STAY

3. This action constituted a challenge to the legality of the plaintiffs' confinement in the various mental health and mental retardation facilities throughout the Commonwealth.

4. Pennsylvania law specifically provides that habeas corpus is the remedy to be used in challenging the legality of one's confinement. Section 426 of the Mental Health and Mental Retardation Act of 1966 provides in relevant part:

> "Every person committed or detained in a facility by reason of the provisions of this act or anyone

[3] District Judge Broderick dissented (Exhibit B).

acting on his behalf, may at any time, petition for a writ of habeas corpus and, except as hereinafter provided, said petition shall be filed in accordance with the provisions of the Act of May 25, 1951 (P.L. 415) [note omitted].

(b) Said petition may be based upon the following grounds:

(1) the insufficiency or illegality of the proceeding leading to such person's commitment . . ."

5. Moreover, this Court has held that it is improper for a federal court to entertain a civil rights action which challenges the legality of one's confinement. *Preiser v. Rodriguez*, 411 U.S. 475 (1973). This Court specifically held that in cases such as those described below, the exclusive remedy is habeas corpus and that a civil rights action was not a permissible alternative.

"Thus, whether the petitioner's challenge to his custody is that the statute under which he stands convicted is unconstitutional, as in Ex parte Siebold, supra; that he had been imprisoned prior to trial on account of a defective indictment against him, as in Ex parte Royall, 117 U.S. 241, 6 S.Ct. 734, 29 L.Ed. 868 (1886); that he is unlawfully confined in the wrong institution, as in In re Bonner, 151 U.S. 242, 14 S.Ct. 323, 38 L.Ed. 149 (1894), and Humphrey v. Cady, 405 U.S. 504, 92 S.Ct. 1048, 31 L.Ed.2d 394 (1972); *that he was denied his constitutional rights at trial,* as in Johnson v. Zerbst, supra; that his guilty plea was invalid, as in Von Moltke v. Gillies, 332 U.S. 708, 68 S.Ct. 316, 92 L.Ed. 309 (1948); that he is being unlawfully detained by the Executive or the military, as in Parisi v. Davidson, 405 U.S. 34, 92 S.Ct. 815, 31 L.Ed.2d 17 (1972); or that his parole was unlawfully revoked, causing him to be reincarcerated in prison, as in Morrissey v. Brewer, 408 U.S. 471, 92 S.Ct. 2593, 33 L.Ed.2d 484 (1972)—*in each case his grievance is that he is being unlawfully subjected to physical restraint, and in each case habeas corpus has been accepted as the specific instrument to obtain release from such confinement.* [note omitted]" (Emphasis added.) 411 U.S. at 486.

6. The lower court in this case not only entertained plaintiffs' challenge to the fact of their confinement within the context of a civil rights action, and thus did not require exhaustion of state remedies, but also ordered that all of the thousands of plaintiffs either be released from confinement, or recommitted pursuant to the procedures established by the court within 120 days. (See Exhibit D, pp. 8-9, para. 15E).

7. The rule of *Preiser* applies fully to this case and all of the considerations underlying that decision, including considerations of comity are applicable to this case.

8. Notwithstanding the fact that a new cause of action in the Commonwealth of Pennsylvania was created by the lower court in this case, the Court Administrator's Office which is the official administrative arm of the Commonwealth's judiciary was not formally brought into this action as a party.

9. The Court Administrator was permitted to comment on the order before it was adopted (Exhibit G).

10. The Court Administrator has informed the lower court of its disapproval of the Order in this case to

the extent that a massive additional case load has been immediately placed upon the dockets of the courts of general jurisdiction in the Commonwealth of Pennsylvania.

11. The lower court's action in this case constitutes improper judicial legislation. Moreover, the order in this case is not narrowly drawn to effectuate its decision, but rather presumes to establish an entire system of juvenile admissions to mental health and mental retardation facilities. As such, the order in this case will cause administrative confusion, unduly interfere with the legislative process, and runs contra to the rule of this court in *Graves v. Barnes*, 405 U.S. 1201 (1972). (See Meyers & Harris affidavits, Exhibits I & J).

12. In short, the order of the lower court has required "the impossible" of the Commonwealth's judiciary and executive, and has preempted the legislature from performing its role in this area of needed legislative action (See letter from Court Administrator to Presiding Judge, Exhibit H).

13. In violation of the Eleventh Amendment to the Constitution of the United States and this Court's holding in *Edelman v. Jordan, supra,* the lower court has ordered that the full panoply of due process rights including the rights to a hearing and counsel be provided retroactively to *all* juveniles presently incarcerated in a mental health or mental retardation facility in the Commonwealth of Pennsylvania.

14. As in *Edelman*, the district court here has issued both prospective and retroactive relief, and as in *Edelman* the retroactive relief was structured to conform with the prospective injunctive relief. And again, as in *Edelman*, "the funds to satisfy the award [retroactive relief] in this

case must inevitably come from the general revenues of the [s]tate . . . ," *id.* at 459. Therefore, the rule of *Edelman* requires reversal of at least this aspect of the lower court's holding.

15. The lower court in this case has ordered the Commonwealth to expend funds from its general fund to provide commitment procedures retroactively even though the Commonwealth "was under no court-imposed obligation to conform to a different standard" *Edelman, supra* at 668.

16. The issues in this case are extremely significant *Times-Picayune Publishing Corp. v. Schulingkamp,* 419 U.S. 1301 (1974). In fact there are currently pending many lawsuits in federal courts involving juveniles' due process rights in the mental health area which will inevitably involve issues similar to those raised by this application and appeal, e.g., *Kidd v. Schmidt,* No. 74-C-605 (E.D. Wisc.); *Poe v. Weinberger,* No. 74-1800 (D.D.C.); *Brown v. Allerton,* No. 75-0450 (E.D. Va.); *Goldy v. Beal,* No. 75-791 (M.D. Pa.) thus it is of critical importance in this area that this Court resolve the fundamental jurisdictional and constitutional questions presently being raised.

17. There is a substantial likelihood of reversal of, at the very least, some of the relief ordered by the lower court on the basis of issues raised by this application and appeal, *Graves v. Barnes,* 405 U.S. 1201 (1972).

18. It is clear that should the requested stay be denied the Commonwealth could never be restored to the *status quo ante* see *Edelman v. Jordan,* 414 U.S. 1301, 1302-3 (1973). All of the funds expended in complying

with the retroactive award of relief would of course be totally irretrievable by the Commonwealth in this case, see also *King v. Smith,* 88 S.Ct. 842 (1968).

19. Similarly, the administrative and judicial disruption and confusion that will result from attempts to implement this decree will cause irreparable harm to the Commonwealth should the lower court's order not be stayed pending this appeal. (See Meyers and Harris affidavits as well as Court Administrator's Letter, Exhibits I, J and H).

20. The plaintiffs will suffer no irreparable harm for there is always available to them the full and complete remedy of habeas corpus pursuant to 50 P.S. §4426.

21. If the stay is not granted in this case judicial review of most, if not all, of appellants' contentions will be precluded because those issues will be moot. This court has in the past found considerations of mootness to be appropriate and sufficient in deciding whether or not to grant a stay of an injunction. In *Republican State Central Committee v. Ripon Society,* in 409 U.S. 1222, 1225 (1972) this Court held that:

> "the fact that a stay here, instead of precluding any judicial review . . . preserves these issues for review in a manner conducive to careful study and consideration is itself a reason to stay the injunction."

See also, *Parisi v. Davidson,* 396 U.S. 1233 (1969); *Public Service Board v. United States,* 87 S.Ct. 3 (1966) and *Bandy v. United States,* 82 S.Ct. 11 (1961).

22. The appellants stand ready to file their jurisdictional statement in such time as this court may direct and thus urge that any delay in the implementation of

the relief ordered by the lower court can be minimized by the granting of an expeditious appeal. *National League of Cities v. Brennan,* 419 U.S. 1321 (1974) (stay granted) 419 U.S. 1100 (1974) (Stay continued; time for jurisdictional statement and response shortened); *Smith v. Richey,* 89 S.Ct. 55 (1968) (stay granted with conditions of expedition).

23. Defendants respectfully request that should this request for a stay be denied that such denial be without prejudice. *National Labor Relations Board v. Getman,* 404 U.S. 1204 (1971).

WHEREFORE, the defendants urgently request that this Court stay the order of the lower court in pending full appellate review of the issues presently before the Court.

Respectfully submitted,

(s) Norman J. Watkins
Norman J. Watkins
Deputy Attorney General

Barry A. Roth
Assistant Attorney General

Robert P. Kane
Attorney General

Of Counsel: Jeffrey Cooper

Dated: December 8, 1975

WESTERN UNION
TELEGRAM

TO: THE CHIEF JUSTICE AND JUSTICES OF THE SUPREME COURT OF THE UNITED STATES 1 FIRST STREET N.E. WASHINGTON D.C. 20543

RE: KREMENS v. BARTLEY, APPEAL FROM U.S. DISTRICT COURT, E.D. PA. #72-2272—REQUEST FOR STAY

ORDER APPEALED FROM CALLS FOR JUDICIAL INTERVENTION IN ESTIMATED SIX TO EIGHT THOUSAND CASES WITHIN FIVE MONTHS. COURT ADMINISTRATOR OF PENNSYLVANIA PREPARING TO INTERVENE IN THE ACTION, IF POSSIBLE, AND HE AND THIS COURT JOIN WITH THE COMMONWEALTH IN THE REQUEST FOR A STAY. FAILURE OF STAY WILL RESULT IN OVERWHELMING AND DISRUPTING THE JUDICIAL SYSTEMS OF PENNSYLVANIA WHICH ARE ALREADY OVERLOADED WITH REGULAR COURT BUSINESS.

BENJAMIN R. JONES
CHIEF JUSTICE OF PENNSYLVANIA

HON. THURGOOD MARSHALL
HON. HARRY A. BLACKMUN
HON. LEWIS F. POWELL, JR.
HON. WILLIAM H. REHNQUIST

SEND TO: (AT ABOVE ADDRESS)
HON. WARREN E. BURGER
HON. WILLIAM J. BRENNAN, JR.
HON. POTTER STEWART
HON. BYRON R. WHITE

SUPREME COURT OF THE UNITED STATES
OFFICE OF THE CLERK
Washington, D.C. 20543
December 15, 1975

Norman J. Watkins, Esq.
Deputy Attorney General of
Pennsylvania
Department of Justice
Harrisburg, Pennsylvania 17120

RE: Jack B. Kremens, et al. v. Kevin B. Bartley, et al., No. A-527

Dear Mr. Watkins:

The Court today entered the following order in the above-entitled case:

The application for a stay of the judgment of the United States District Court for the Eastern District of Pennsylvania (Civil Action No. 72-2272), presented to Mr. Justice Rehnquist and by him referred to the Court, is granted.

Very truly yours,

Michael Rodak, Jr., *Clerk*
by Francis J. Lorson
Francis J. Lorson
Deputy Clerk

cc: David Ferleger, Esquire
1427 Walnut Street
Philadelphia, Pennsylvania 19102

Clerk, USDC for ED Pennsylvania
(No. 72-2272)